PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CERTIFIED MAIL #: 7015 0640 0003 5695 6900
May 19, 2017

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Re: Lake Minnetonka Shores - Independent Informal Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5210
Project # S5210025

Dear Ms. Beaudot:

This is in response to your letter of September 30, 2016, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tags F309 issued pursuant to the survey event KN7Z11, completed on August 31, 2016. On November 4, 2016, the facility's counsel requested a change from IDR to IIDR via email.

The information presented with your letter, the CMS 2567 dated August 31, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F309 S/S-G 42 CFR § 483.25 Provide Care/services For Highest Well Being

Summary of facts:

R148 was admitted to LMS on May 18, 2016. R148 with multiple diagnoses, a documented history of falls at home, and previously demonstrated blood pressure instability. R148 's code status upon admission was Do Not Resuscitate Do Not Intubate (DNR/DNI).

Within a few days of admission, R148 had two (2) falls on May 22, 2016. The facility notified the patient's PCP and family, after providing care and neurological checks. On May 23, 2016, the patient remained weak and bedbound, her pupil reaction times were notably delayed. A physical therapist noted that R148 was fatigued, shaky, and had a grey pallor. A nurse was notified verify that R148s vital signs were within normal limits. These changes in R148's condition were not communicated to R148's physician. ater the evening of May 23, 2016, R148's roommate called a nurse for assistance after a loud crash woke her up. The nurse found R148 on the floor and not breathing and without a pulse. As R148's code status was DNR/DNI the nurse contacted R148's family member.

Summary of facility's reason for IDR of F309:

The facility disputed the findings at F309 based on the patient R148s In investigating this situation, surveyors determined that the facility was not in compliance with F309 because it had not notified R148'a physician of the change in her condition on May 23, 2016. Moreover, they wrote the deficiency with a based on statement that implied her death was related to head trauma sustained during her second fall, rather than considering the subsequent changes in her condition as symptoms of other underlying health conditions. The failure to notify the physician of the change in R148's condition precluded the opportunity for the physician to make changes to her care plan. In the information submitted for the IIDR, the facility included the hospital discharge summary. This independent report supports that R148's death was due to irreversible decline in health and could not be attributable to the fall. While a deficient practice did exist in that R148's changes in condition, specifically increased weakness, changes in her pupil reaction status and grey coloring were not reported in a timely manner after her second fall, this did not result in actual harm to R148.

Summary of findings:

After careful review of Judge LaFave's recommendation and the material submitted to the Judge in support of each party's position, Commissioner Ehlinger concurred with Judge LaFave's recommendation that tag F309 is affirmed as a deficiency and that the scope and severity be amended to a Level D, potential for harm that is not immediate jeopardy.

The Statement of Deficiencies, CMS 2567 and CMS 2567B, have been revised to reflect the Commissioner's decision as delineated in the letter dated March 21, 2017. The revised CMS 2567 and CMS 2567B have been submitted electronically, and are enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz
HFE NURSING EVALUATOR II
Minnesota Department of Health
Health Regulation Division
Licensing and Certification Program
12 Civic Center Plaza, Suite #2105
Mankato Place
Mankato, MN 56001
Holly.Kranz@s tate.mn.us
p 507-344-2742 | c 320-292-7255 | f 507-344-2723

cc: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Pam Kerssen, Assistant Program Manager
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 ______	08/31/2016

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 8/29/16, to 8/31/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Lake Minnetonka Shores was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time	F 156		9/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/30/2016

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 ______	08/31/2016

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 156	Continued From page 1	F 156		

of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

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 ______	08/31/2016

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 156	Continued From page 2 groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Non-Coverage for 1 of 3 residents (R93) reviewed for liability notices. Findings include: R93's progress note dated 7/13/16, identified R93 would be completing therapy and discharge back to assisted living on 7/15/16. R93 had, "No further recommendations for continued therapy."	F 156	Resident 93 was discharged prior to adequate notice given related to family and resident's wishes to discharge earlier than anticipated end date of therapy. Corrective Action as it applies to other residents: The policy and procedure for Medicare Denials was reviewed and is current. To prevent reoccurrence for other residents the criteria for denial for	

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 ______	08/31/2016

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 156	Continued From page 3 R93's medical record was reviewed. There was no evidence R93 had been provided a Notice of Medicare Non-Coverage (CMS-10123) as required when their Medicare coverage was ended. During interview on 8/31/16, at 3:55 p.m. licensed social worker (LSW)-A stated R93 admitted to the nursing home for therapy services under Medicare Part A coverage. R93 completed his therapy services and was originally planned to discharge on Saturday, 7/16/16, however the assisted living would not accept him on the weekend. LSW-A stated a decision was made with R93's family to move up his discharge to Friday, 7/15/16, instead. LSW-A stated R93 was not provided a Notice of Medicare Non-Coverage (CMS-10123) because R93, "Chose to go on his own wishes prior to the last day."	F 156	Medicare benefits is reviewed daily at IDT meetings. In-service for this group will be held the week of 9/26/2016. Specific training and tool kits were created for staff responsible for providing notices. Reoccurrence will be prevented by: Audits will be done weekly by the Resident Services Director (LSW) or designee. The audits will be reviewed monthly to check for criteria of discharge to make sure notices are given timely. Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Administrator will be responsible for compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157		10/7/16

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 ______	08/31/2016

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 4 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform the resident's physician of pertinent information about the resident's status after the resident fell for 1 of 2 residents (R148) reviewed for falls. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. The 5/23/16 admission Minimum Data Set identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. Comprehensive Data Collection form dated	F 157	Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and	

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 ______	08/31/2016

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 5 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Neurological status noted weakness and a history of and risk for falls. R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls. The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait. The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16 identified R146 was" Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was filled out by Physical Therapy-A. A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R146 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via	F 157	timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention. Reoccurrence will be prevented by: a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family. b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Clinical Administrator will be responsible for ongoing compliance.	

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 ______	08/31/2016

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		F 157		

Continued From page 6
voicemail at 6:35 p.m. of the fall.

A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "Pressure to stop bleeding" and "Cold compress to hematoma". The medical provider was notified by fax on 5/23/16 at 1:10 a.m. of the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall 79/49.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16 at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration to the back/top of R148's head. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form sent to the physician faxed on 5/23/16 which was hand written on the form. The form identified "6:00 p.m. while ambulating to dining room 'my knees gave

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 ______	08/31/2016

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 7	F 157		

out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified "9:00 pm. Resident 'thought she could do it herself" and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked "noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R146 and R146 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was filled out by physical therapy assistant-A.

R148's Care Conference Summary dated 5/23/16, identified R148 "Had 2 falls on Sunday, did hit head". It also noted "Had increase in weakness over the weekend and increased shakiness." The summary noted "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148 progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD,

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 ______	08/31/2016

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		F 157		

Continued From page 8
"fall noted".

- 5/23/16 at 8:23 am titled care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box with observed on floor, "bleeding on R [right] cheek." Medical attention required, no;

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 ______	08/31/2016

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 9	F 157		

first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes from 5/19/16 to 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT-Therapist Progress & Discharge Summary dated 5/24/16, identified "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted "Skilled services provided since start of care included There ex [therapeutic exercises], gait training And pt education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R148) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on

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 ______	08/31/2016

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 10	F 157		

5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, with a change in status the MD should be notified.

When interviewed on 8/31/16, at 4:46 p.m. medical doctor (MD)-A stated a fax was received on 5/23/16 at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status. "We didn't know that she was bleeding." Notification received from the facility included a

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 ______	08/31/2016

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 11	F 157		

routine fax to sign orders for therapy, and the next was a notification of her death. "Nowhere did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but "given her history you gotta wonder."

Although R148 showed a change in her medical status after her fall and subsequent death on 5/23/16, the facility had not recognized and comprehensively assessed these medical changes and failed to contact the physician for possible medical interventions for R148.

A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls.

A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions.

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 ______	08/31/2016

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 241	Continued From page 12	F 241		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified rising routine was consistently provided for 1 of 3 residents (R80) reviewed for dignity. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. During interview on 8/29/16, at 4:24 p.m. R80 stated she did not feel staff treated her with dignity because it seemed, "Like there's always a lag of time," in getting assistance with cares and dressing. R80 stated the staff often start helping her then, "Leave the room and not come back," so R80 has to, "Lay there on the bed waiting for someone to help finish dressing me." R80 stated this happens, "All the time," and it makes her feel, "Rejected and uncared for." On 8/31/16, at 7:54 a.m. R80 was in bed in her room with her call light turned on. Licensed practical nurse (LPN)-B entered the room and turned off R80's call light. LPN-B applied a cream to R80's legs and asked her, "Are you	F 241	Corrective Action: To correct the deficient practice for resident #80, LSW interviewed resident to make sure we have proper understanding of what time the resident would prefer to rise and go to bed. Weekly check-ins with Resident Services for this resident will occur to ensure resident needs are being met. Corrective Action as it applies to other residents: The policy and procedure for call light response and dignity were reviewed and are current. All resident preferences are assessed upon admission, minimally quarterly and as indicated with a change in request of services from family or resident. All staff are trained on timely response of call lights and meeting resident requests upon hire and minimally annually with annual training. An in-service will be provided to review the importance of resident preferences and Dignity policy during the week of October 3, 2016. This topic will be discussed at resident council upcoming in October as to resident preference and timeliness of services. Household residents will be interviewed by	10/7/16

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 ______	08/31/2016

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 241	Continued From page 13 ready to get up?" R80 stated she had, "Been waiting to get up," to which LPN-B stated she would inform the nursing assistant (NA) staff. At 7:57 a.m. R80 again turned on her call light outside the room. LPN-B entered the room and turned off the call light and told R80 the NA staff would be coming, "In a minute." LPN-B then applied a warm washcloth to R80's eyes and left the room. At 8:25 a.m. R80 remained in bed without any assistance being offered to help her get up or ready for the day as she had requested. R80 stated she was, "Waiting on my aides [NA]," and had been waiting for help to get up, "since 7:30 [a.m.]." R80 stated having to wait this long for help had happened before, and it makes her feel, "Lonelier because I have to eat by myself [in the dining room]." At 8:29 a.m. (thirty five minutes after observation began) NA-A entered R80's room and helped her get dressed for the day. At 9:28 a.m. R80 was assisted out of her room to the dining room and seated at a table by herself, with only two other residents seated in the dining room at a different table. R80 was served breakfast alone in the dining room. When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80 had complained about not being helped timely in the morning before to her, and residents sometimes have to wait for longer periods if they are short staffed because they are typically, "Really behind," then. During interview on 8/31/16, at 10:03 a.m. LPN-B stated staff, "Try to get them [residents] as we can," and sometimes R80, "Has to wait a little bit" for her cares in the morning.	F 241	LSW to learn preference on what time the residents would like to get up and go to sleep each day. A committee has been formed to discuss ongoing staffing patterns in the morning/evening and how we can best meet our residents preferences. Reoccurrence will be prevented by: Weekly Audits will be done on 10% of the residents to ensure resident s preferences are being met when it comes to preferred wake times and the times they are going to bed. Residents preferred wake times will be added to NAR team sheets. Audits of timely response rates will also be conducted to ensure ongoing needs are being met timely. The Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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 ______ B. WING ______	08/31/2016

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 241	Continued From page 14 When interviewed on 8/31/16, at 12:20 p.m. LPN clinical coordinator (LPN)-C stated residents should not have to wait for extended periods to be helped with cares adding, "We don't ever want anyone to wait a long period of time," because, "This is their home and they need to feel trust in us." A facility Dignity policy dated 12/2014, identified resident should be cared for, "In a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions to promote skin integrity for 1 of 4 residents (R80) reviewed for pressure ulcers. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's care plan dated 8/3/16, identified R80 had,	F 282	Corrective Action: To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected and staff involved were re-educated on resident plan of care. The care plan was reviewed and is current. The Team Sheet was updated to match Care Plan interventions. Corrective Action as it applies to other residents: The policy and procedure for care plan was reviewed and is current. All residents are assessed on admission and care plan initiated. All residents care plan	10/7/16

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 ______	08/31/2016

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 282 Continued From page 15

"Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed."

During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft."

When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red."

During interview on 8/31/16, at 9:52 a.m. licensed practical nurse (LPN)-B stated the care plan was used as an, "Overall guide on how to take care of that person," and staff were to, "Follow the care plan the way its supposed to be followed."

When interviewed on 8/31/16, at 1:56 p.m. LPN-C stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't.

F 282

and My Best Day/assignment sheet are reviewed minimally quarterly and with change in status and updated with any changes. We will audit the team sheets to make sure the current team sheets match the care plan for each resident. When there is a change in care the Clinical Coordinators (or designee) will update the team sheets and the care plan. There will be an in-service regarding the process of updating of care plan and team sheets for all nursing the week of October 3, 2016.

Reoccurrence will be prevented by:
Weekly Audits will be completed by Clinical Coordinators. They will chose 10% of the residents each week to make sure care plans match team sheets and that the services indicated on the plan of care are being followed.

The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. Administrator will report audits to the QA Team. QA will determine frequency of audits
c. The 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 ______ B. WING ______	08/31/2016

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 282	Continued From page 16 A facility Care Plan Policy and Procedure dated 4/2016, identified a care plan was used to, "Ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess and monitor a significant change about a resident's status after the resident fell, for 1 of 2 residents (R148) reviewed for accidents. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. R148's admission Minimum Data Set dated 5/23/16, identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. R148's Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to	F 309	Resident #148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An in-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider	10/7/16

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 ______	08/31/2016

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 309 Continued From page 17

person, place and time, with level of consciousness as alert. Further, the neurological status noted weakness and a history of and risk for falls.

R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls.

The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait.

The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16, identified R148 was "Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was completed by Physical Therapist (PT)-A.

A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R148 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via

F 309

team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention.

Reoccurrence will be prevented by:
a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.
b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends.

The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. Administrator will report audits to the QA Team. QA will determine frequency of audits
c. The Clinical Administrator will be responsible for ongoing compliance.

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 ______	08/31/2016

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 309	Continued From page 18	F 309		

voicemail at 6:35 p.m. of the fall.

A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "pressure to stop bleeding" and "cold compress to hematoma." The medical provider was notified by fax on 5/23/16, at 1:10 a.m., 4 hours and 10 minutes after the injury from the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall was 79/49. The Fall Huddle Review Form dated 5/22/16 identified a drawing of the residents position in relation to other items. The picture identified R148's head was touching a dresser, which was next to the residents television.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16, at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

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 ______	08/31/2016

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 309	Continued From page 19	F 309		

A Facility Facsimile Transmittal Form was faxed to the the physician with a faxed date identified as 5/23/16, which was hand written on the form. The form identified: "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified: "9:00 pm. Resident 'thought she could do it herself' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked, "Noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

An undated facility Falls Follow Up Form for R148 was reviewed. The form lacked date or time of the occurrence, however identified long term interventions of resident changed to assist of one with all transfers, and therapy notified of increased weakness. Neuro at baseline and INR (international normalized ratio), a laboratory test for measurement of anticoagulants for blood clotting, was within normal limits. There was no date or time identified of when this form was completed for the long term interventions.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R148. R148 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was

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 ______	08/31/2016

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 309	Continued From page 20	F 309		

completed by physical therapy assistant-A.

R146's Care Conference Summary dated 5/23/16, identified: "[R148] had 2 falls on Sunday, did hit head." It also noted: "Had increase in weakness over the weekend and increased shakiness." The summary noted: "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148's progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

- 5/23/16 at 8:23 am care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

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 ______	08/31/2016

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 309		F 309		

Continued From page 21

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box observed on floor and, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes on 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT - Therapist Progress & Discharge Summary dated 5/24/16, identified: "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted: "Skilled services provided since start of care

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 ______	08/31/2016

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 309	Continued From page 22	F 309		

included There ex [therapeutic exercises], gait training and pt [patient] education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R146) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would

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 ______	08/31/2016

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 309	Continued From page 23	F 309		

definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, and with a change in status the medical doctor (MD) should be notified.

When interviewed on 8/31/16, at 4:46 p.m. MD-A stated a fax was received on 5/23/16, at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status and stated, "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. MD-A added, "No where did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but added, "Given her history you gotta wonder."

R148 was admitted to the facility on 5/18/16, and was independent with; toileting, transferring from bed to chair, sit to stand, walking in her room and only needed staff assistance of one, if ambulating more than 100 feet. R148 sustained 2 falls, on 5/23/16, following the fall on 5/23/16 at 9:00 p.m. R148 hit her head. R148 had changes in her medical status less than 24 hours after the fall. R148 complained she was not feeling very well, was gray in color, shaky and needed staff assistance with transfers and toileting even though she was previously independent with this.

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 ______	08/31/2016

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 309	Continued From page 24 R148 also needed additional staff assistance for ambulation at all times, which was a change from assistance of one staff for long distances of 100+ feet, and had neurological changes in her pupil status 12 hours after her fall. Although R148 showed a change in her medical status after her fall on 5/22/16, the facility had not recognized and comprehensively reassess these medical changes and failed to contact the physician for possible medical interventions. A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls. A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		10/7/16

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 ______	08/31/2016

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 314	Continued From page 25 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the risk of pressure ulcer formation for 1 of 4 residents (R80) reviewed for pressure ulcer care. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's Skin Risk and Braden assessment, dated 7/20/16, identified R80 to have fragile skin and signs and symptoms of neuropathy with, "Tingling sensation of lower extremity or feet." Further, the assessment identified R80 was at, "Mild Risk" or developing pressure ulcers. R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." R80's most recent Body Audit dated 8/15/16,	F 314	To correct this for resident #80, staff completed a Braden and Skin Risk Assessment to make the Care Plan correct and updated care plan/Team Sheets. Corrective Action as it applies to other residents: The policy and procedure for skin risk and pressure ulcer prevention was reviewed and is current. To prevent reoccurrence for other residents we will pull a report of all pressure issues in Point Click Care and audit the Care Plan to make sure the proper instructions are on Team Sheets. An in-service will be held reviewing the Skin at Risk Policy to follow floating of heels and points of pressure. The Team Sheets will be reviewed to insure all areas of concern are addressed. All residents are assessed upon admission for skin risk and the care plan and my best day/ team sheet updated with interventions. All residents are assessed minimally quarterly and with change of status impacting risk and the care plan and my best day/ team sheet are updated to reflect interventions or changes in skin	

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 ______	08/31/2016

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 314 | F 314

Continued From page 26

identified R80 had no current pressures and her heels were described as, "Clear."

During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft."

When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red."

During interview on 8/31/16, at 12:20 p.m. licensed practical nurse clinical coordinator (LPN)-B stated R80 was at, "Slight risk for pressure ulcers" because of her impaired mobility and incontinence. LPN-B stated she was unaware of any concerns for R80 concerning her heels which would cause them to be red, [I'm] not aware of anything wrong with her heels." LPN-B stated if staff attempted to float her heels and she refused, it should be documented however, LPN-B stated there was, "No documentation to support" they had been floated during the previous night or morning.

risk.

Reoccurrence will be prevented by:
Clinical Coordinator or designee auditing the care plan, assessment and team sheets to ensure all of the information is accurate. Staff will audit 10% of the residents each week to make sure all areas are matching and that the interventions are in place.

The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. The Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits.
c. The 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 ______ B. WING ______	08/31/2016

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 314	Continued From page 27 When interviewed again on 8/31/16, at 1:56 p.m. LPN-B stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't. A facility Skin Risk Policy dated 8/2016, identified a directive to, "Implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care." Further, the policy provided general care guidelines for staff to follow which included, "Elevate heels off bed as indicated..."	F 314		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245210	A. Building B. Wing	10/27/2016

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).

REVISED

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 10/07/2016	ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 09/30/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 10/07/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 10/07/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 10/07/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 10/07/2016
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 (INITIALS) PK/KJ	DATE 10/15/2016	SIGNATURE OF SURVEYOR 32209	DATE 10/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/31/2016	☐ 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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KN7Z
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 **10/31/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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 :
Brenda Fischer, HFE NE II 10/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/15/2016 (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 11/18/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **11/01/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245210
November 15, 2016

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Dear Ms. Beaudot:

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 October 7, 2016 the above facility is certified for or 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.

An equal opportunity employer.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

RE: Project Number S5210025

Dear Ms. Beaudot:

On September 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 31, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 11, 2016 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 August 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 31, 2016, effective October 7, 2016 and therefore remedies outlined in our letter to you dated September 21, 2016, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245210 (Y1)	A. Building B. Wing (Y2)	10/27/2016 (Y3)

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 10/07/2016	ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 09/30/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 10/07/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 10/07/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 10/07/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 10/07/2016
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 (INITIALS) PK/KJ	DATE 10/15/2016	SIGNATURE OF SURVEYOR 32209	DATE 10/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/31/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245210	A. Building 01 - MAIN BUILDING 01 B. Wing	10/11/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 09/06/2016	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	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 (INITIALS) TL/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 32209	DATE 10/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/2/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245210	A. Building 02 - BLDG TWO B. Wing	10/11/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 09/06/2016	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	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 (INITIALS) TL/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 32209	DATE 10/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00271 Y1	A. Building B. Wing Y2	10/27/2016 Y3

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265 Reg. # MN Rule 4658.0085 LSC	Correction Completed 10/07/2016	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 10/07/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 10/07/2016
ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 10/07/2016	ID Prefix 21800 Reg. # MN St. Statute144.651 Subd. 4 LSC	Correction Completed 09/30/2016	ID Prefix 21805 Reg. # MN St. Statute 144.651 Subd. 5 LSC	Correction Completed 10/07/2016
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 (INITIALS) PK/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 32209	DATE 10/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/31/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Re: Reinspection Results - Project Number S5210025

Dear Ms. Beaudot:

On October 27, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 31, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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: KN7Z
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: **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 **08/31/2016** (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:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC
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 :
Austin Fry, HFE NE II 10/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/27/2016 (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 11/01/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 21, 2016

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

RE: Project Number S5210025

Dear Ms. Beaudot:

On August 31, 2016, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;

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

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

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

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 October 12, 2016, 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 October 12, 2016 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 December 1, 2016 (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 March 1, 2017 (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 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
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

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 ______	08/31/2016

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 8/29/16, to 8/31/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Lake Minnetonka Shores was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 10/03/16 gPN		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time	F 156		9/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/30/2016

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 ______	08/31/2016

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 156	Continued From page 1	F 156		

of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

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 ______	08/31/2016

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 156	Continued From page 2 groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Non-Coverage for 1 of 3 residents (R93) reviewed for liability notices. Findings include: R93's progress note dated 7/13/16, identified R93 would be completing therapy and discharge back to assisted living on 7/15/16. R93 had, "No further recommendations for continued therapy."	F 156	Resident 93 was discharged prior to adequate notice given related to family and resident's wishes to discharge earlier than anticipated end date of therapy. Corrective Action as it applies to other residents: The policy and procedure for Medicare Denials was reviewed and is current. To prevent reoccurrence for other residents the criteria for denial for	

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 ______	08/31/2016

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 156	Continued From page 3 R93's medical record was reviewed. There was no evidence R93 had been provided a Notice of Medicare Non-Coverage (CMS-10123) as required when their Medicare coverage was ended. During interview on 8/31/16, at 3:55 p.m. licensed social worker (LSW)-A stated R93 admitted to the nursing home for therapy services under Medicare Part A coverage. R93 completed his therapy services and was originally planned to discharge on Saturday, 7/16/16, however the assisted living would not accept him on the weekend. LSW-A stated a decision was made with R93's family to move up his discharge to Friday, 7/15/16, instead. LSW-A stated R93 was not provided a Notice of Medicare Non-Coverage (CMS-10123) because R93, "Chose to go on his own wishes prior to the last day."	F 156	Medicare benefits is reviewed daily at IDT meetings. In-service for this group will be held the week of 9/26/2016. Specific training and tool kits were created for staff responsible for providing notices. Reoccurrence will be prevented by: Audits will be done weekly by the Resident Services Director (LSW) or designee. The audits will be reviewed monthly to check for criteria of discharge to make sure notices are given timely. Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Administrator will be responsible for compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157		10/7/16

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 ______	08/31/2016

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 4 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform the resident's physician of pertinent information about the resident's status after the resident fell for 1 of 2 residents (R148) reviewed for falls. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. The 5/23/16 admission Minimum Data Set identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. Comprehensive Data Collection form dated	F 157	Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and	

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 ______	08/31/2016

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 5 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Neurological status noted weakness and a history of and risk for falls. R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls. The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait. The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16 identified R146 was" Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was filled out by Physical Therapy-A. A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R146 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via	F 157	timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention. Reoccurrence will be prevented by: a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family. b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Clinical Administrator will be responsible for ongoing compliance.	

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 ________	08/31/2016

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 6	F 157		

voicemail at 6:35 p.m. of the fall.

A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "Pressure to stop bleeding" and "Cold compress to hematoma". The medical provider was notified by fax on 5/23/16 at 1:10 a.m. of the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall 79/49.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16 at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration to the back/top of R148's head. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form sent to the physician faxed on 5/23/16 which was hand written on the form. The form identified "6:00 p.m. while ambulating to dining room 'my knees gave

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 ______	08/31/2016

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 7	F 157		

out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified "9:00 pm. Resident 'thought she could do it herself'' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked "noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R146 and R146 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was filled out by physical therapy assistant-A.

R148's Care Conference Summary dated 5/23/16, identified R148 "Had 2 falls on Sunday, did hit head". It also noted "Had increase in weakness over the weekend and increased shakiness." The summary noted "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148 progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD,

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 ______	08/31/2016

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 8	F 157		

"fall noted".

- 5/23/16 at 8:23 am titled care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box with observed on floor, "bleeding on R [right] cheek." Medical attention required, no;

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 ______	08/31/2016

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 9	F 157		

first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes from 5/19/16 to 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT-Therapist Progress & Discharge Summary dated 5/24/16, identified "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted "Skilled services provided since start of care included There ex [therapeutic exercises], gait training And pt education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R148) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on

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 ______	08/31/2016

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 10	F 157		

5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, with a change in status the MD should be notified.

When interviewed on 8/31/16, at 4:46 p.m. medical doctor (MD)-A stated a fax was received on 5/23/16 at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status. "We didn't know that she was bleeding." Notification received from the facility included a

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 ______	08/31/2016

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 11 routine fax to sign orders for therapy, and the next was a notification of her death. "Nowhere did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but "given her history you gotta wonder." Although R148 showed a change in her medical status after her fall and subsequent death on 5/23/16, the facility had not recognized and comprehensively assessed these medical changes and failed to contact the physician for possible medical interventions for R148. A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls. A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions.	F 157		

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 ______	08/31/2016

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 241	Continued From page 12	F 241		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified rising routine was consistently provided for 1 of 3 residents (R80) reviewed for dignity. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. During interview on 8/29/16, at 4:24 p.m. R80 stated she did not feel staff treated her with dignity because it seemed, "Like there's always a lag of time," in getting assistance with cares and dressing. R80 stated the staff often start helping her then, "Leave the room and not come back," so R80 has to, "Lay there on the bed waiting for someone to help finish dressing me." R80 stated this happens, "All the time," and it makes her feel, "Rejected and uncared for." On 8/31/16, at 7:54 a.m. R80 was in bed in her room with her call light turned on. Licensed practical nurse (LPN)-B entered the room and turned off R80's call light. LPN-B applied a cream to R80's legs and asked her, "Are you	F 241	Corrective Action: To correct the deficient practice for resident #80, LSW interviewed resident to make sure we have proper understanding of what time the resident would prefer to rise and go to bed. Weekly check-ins with Resident Services for this resident will occur to ensure resident needs are being met. Corrective Action as it applies to other residents: The policy and procedure for call light response and dignity were reviewed and are current. All resident preferences are assessed upon admission, minimally quarterly and as indicated with a change in request of services from family or resident. All staff are trained on timely response of call lights and meeting resident requests upon hire and minimally annually with annual training. An in-service will be provided to review the importance of resident preferences and Dignity policy during the week of October 3, 2016. This topic will be discussed at resident council upcoming in October as to resident preference and timeliness of services. Household residents will be interviewed by	10/7/16

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 ______	08/31/2016

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 241	Continued From page 13 ready to get up?" R80 stated she had, "Been waiting to get up," to which LPN-B stated she would inform the nursing assistant (NA) staff. At 7:57 a.m. R80 again turned on her call light outside the room. LPN-B entered the room and turned off the call light and told R80 the NA staff would be coming, "In a minute." LPN-B then applied a warm washcloth to R80's eyes and left the room. At 8:25 a.m. R80 remained in bed without any assistance being offered to help her get up or ready for the day as she had requested. R80 stated she was, "Waiting on my aides [NA]," and had been waiting for help to get up, "since 7:30 [a.m.]." R80 stated having to wait this long for help had happened before, and it makes her feel, "Lonelier because I have to eat by myself [in the dining room]." At 8:29 a.m. (thirty five minutes after observation began) NA-A entered R80's room and helped her get dressed for the day. At 9:28 a.m. R80 was assisted out of her room to the dining room and seated at a table by herself, with only two other residents seated in the dining room at a different table. R80 was served breakfast alone in the dining room. When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80 had complained about not being helped timely in the morning before to her, and residents sometimes have to wait for longer periods if they are short staffed because they are typically, "Really behind," then. During interview on 8/31/16, at 10:03 a.m. LPN-B stated staff, "Try to get them [residents] as we can," and sometimes R80, "Has to wait a little bit" for her cares in the morning.	F 241	LSW to learn preference on what time the residents would like to get up and go to sleep each day. A committee has been formed to discuss ongoing staffing patterns in the morning/evening and how we can best meet our residents preferences. Reoccurrence will be prevented by: Weekly Audits will be done on 10% of the residents to ensure resident s preferences are being met when it comes to preferred wake times and the times they are going to bed. Residents preferred wake times will be added to NAR team sheets. Audits of timely response rates will also be conducted to ensure ongoing needs are being met timely. The Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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 ______ B. WING ______	08/31/2016

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 241	Continued From page 14 When interviewed on 8/31/16, at 12:20 p.m. LPN clinical coordinator (LPN)-C stated residents should not have to wait for extended periods to be helped with cares adding, "We don't ever want anyone to wait a long period of time," because, "This is their home and they need to feel trust in us." A facility Dignity policy dated 12/2014, identified resident should be cared for, "In a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions to promote skin integrity for 1 of 4 residents (R80) reviewed for pressure ulcers. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's care plan dated 8/3/16, identified R80 had,	F 282	Corrective Action: To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected and staff involved were re-educated on resident plan of care. The care plan was reviewed and is current. The Team Sheet was updated to match Care Plan interventions. Corrective Action as it applies to other residents: The policy and procedure for care plan was reviewed and is current. All residents are assessed on admission and care plan initiated. All residents care plan	10/7/16

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 ______	**08/31/2016**

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 282	Continued From page 15 "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 9:52 a.m. licensed practical nurse (LPN)-B stated the care plan was used as an, "Overall guide on how to take care of that person," and staff were to, "Follow the care plan the way its supposed to be followed." When interviewed on 8/31/16, at 1:56 p.m. LPN-C stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't.	F 282	and My Best Day/assignment sheet are reviewed minimally quarterly and with change in status and updated with any changes. We will audit the team sheets to make sure the current team sheets match the care plan for each resident. When there is a change in care the Clinical Coordinators (or designee) will update the team sheets and the care plan. There will be an in-service regarding the process of updating of care plan and team sheets for all nursing the week of October 3, 2016. Reoccurrence will be prevented by: Weekly Audits will be completed by Clinical Coordinators. They will chose 10% of the residents each week to make sure care plans match team sheets and that the services indicated on the plan of care are being followed. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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 ______ B. WING ______	08/31/2016

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 282	Continued From page 16 A facility Care Plan Policy and Procedure dated 4/2016, identified a care plan was used to, "Ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible."	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess and monitor a significant change about a resident's status after the resident fell, for 1 of 2 residents (R148) reviewed for accidents. This resulted in actual harm for R148, after developing a cranial hematoma, laceration and died. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. R148's admission Minimum Data Set dated 5/23/16, identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days.	F 309	Resident #148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An in-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider	10/7/16

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 ______	08/31/2016

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 309	Continued From page 17	F 309		

R148's Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Further, the neurological status noted weakness and a history of and risk for falls.

R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls.

The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait.

The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16, identified R148 was "Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was completed by Physical Therapist (PT)-A.

A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R148 had a witnessed fall without injury. R148 was walking to the dining

team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention.

Reoccurrence will be prevented by:
a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.
b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends.

The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. Administrator will report audits to the QA Team. QA will determine frequency of audits
c. The Clinical Administrator will be responsible for ongoing compliance.

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 ______	08/31/2016

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 309	Continued From page 18	F 309		

room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via voicemail at 6:35 p.m. of the fall.

A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "pressure to stop bleeding" and "cold compress to hematoma." The medical provider was notified by fax on 5/23/16, at 1:10 a.m., 4 hours and 10 minutes after the injury from the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall was 79/49. The Fall Huddle Review Form dated 5/22/16 identified a drawing of the residents position in relation to other items. The picture identified R148's head was touching a dresser, which was next to the residents television.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16, at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry

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 ______	08/31/2016

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 309	Continued From page 19	F 309		

showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form was faxed to the the physician with a faxed date identified as 5/23/16, which was hand written on the form. The form identified: "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified: "9:00 pm. Resident 'thought she could do it herself' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked, "Noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

An undated facility Falls Follow Up Form for R148 was reviewed. The form lacked date or time of the occurrence, however identified long term interventions of resident changed to assist of one with all transfers, and therapy notified of increased weakness. Neuro at baseline and INR (international normalized ratio), a laboratory test for measurement of anticoagulants for blood clotting, was within normal limits. There was no date or time identified of when this form was completed for the long term interventions.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R148. R148 needed assistance of one for toileting, bed to chair/chair to bed transfers

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 ______	08/31/2016

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 309	Continued From page 20	F 309		

and sit to stand. A change was made to walking with assistance of one at all times. The form was completed by physical therapy assistant-A.

R146's Care Conference Summary dated 5/23/16, identified: "[R148] had 2 falls on Sunday, did hit head." It also noted: "Had increase in weakness over the weekend and increased shakiness." The summary noted: "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148's progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

- 5/23/16 at 8:23 am care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on

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 ______	08/31/2016

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 309		F 309		

Continued From page 21
back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box observed on floor and, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes on 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT - Therapist Progress & Discharge Summary dated 5/24/16, identified: "Pt [patient] passed away unexpectedly last night following

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 ______	08/31/2016

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 309	Continued From page 22	F 309		

decline over the past few days." It also noted: "Skilled services provided since start of care included There ex [therapeutic exercises], gait training and pt [patient] education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R146) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was

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 ______	08/31/2016

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 309	Continued From page 23	F 309		

unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, and with a change in status the medical doctor (MD) should be notified.

When interviewed on 8/31/16, at 4:46 p.m. MD-A stated a fax was received on 5/23/16, at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status and stated, "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. MD-A added, "No where did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but added, "Given her history you gotta wonder."

R148 was admitted to the facility on 5/18/16, and was independent with; toileting, transferring from bed to chair, sit to stand, walking in her room and only needed staff assistance of one, if ambulating more than 100 feet. R148 sustained 2 falls, on 5/23/16, following the fall on 5/23/16 at 9:00 p.m. R148 hit her head. R148 had changes in her medical status less than 24 hours after the fall. R148 complained she was not feeling very well, was gray in color, shaky and needed staff

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 ______	08/31/2016

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 309	Continued From page 24 assistance with transfers and toileting even though she was previously independent with this. R148 also needed additional staff assistance for ambulation at all times, which was a change from assistance of one staff for long distances of 100+ feet, and had neurological changes in her pupil status 12 hours after her fall. Although R148 showed a change in her medical status after her fall on 5/22/16, the facility had not recognized and comprehensively reassess these medical changes and failed to contact the physician for possible medical interventions which resulted in actual harm for R148 who subsequently died. A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls. A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions.	F 309		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		10/7/16

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 ______	08/31/2016

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 314 SS=D	Continued From page 25 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the risk of pressure ulcer formation for 1 of 4 residents (R80) reviewed for pressure ulcer care. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's Skin Risk and Braden assessment, dated 7/20/16, identified R80 to have fragile skin and signs and symptoms of neuropathy with, "Tingling sensation of lower extremity or feet." Further, the assessment identified R80 was at, "Mild Risk" or developing pressure ulcers. R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in	F 314	To correct this for resident #80, staff completed a Braden and Skin Risk Assessment to make the Care Plan correct and updated care plan/Team Sheets. Corrective Action as it applies to other residents: The policy and procedure for skin risk and pressure ulcer prevention was reviewed and is current. To prevent reoccurrence for other residents we will pull a report of all pressure issues in Point Click Care and audit the Care Plan to make sure the proper instructions are on Team Sheets. An in-service will be held reviewing the Skin at Risk Policy to follow floating of heels and points of pressure. The Team Sheets will be reviewed to insure all areas of concern are addressed. All residents are assessed upon admission for skin risk and the care plan and my best day/ team sheet updated with interventions. All residents are assessed minimally quarterly and with change of	

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 ______	08/31/2016

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 314	Continued From page 26 bed." R80's most recent Body Audit dated 8/15/16, identified R80 had no current pressures and her heels were described as, "Clear." During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 12:20 p.m. licensed practical nurse clinical coordinator (LPN)-B stated R80 was at, "Slight risk for pressure ulcers" because of her impaired mobility and incontinence. LPN-B stated she was unaware of any concerns for R80 concerning her heels which would cause them to be red, [I'm] not aware of anything wrong with her heels." LPN-B stated if staff attempted to float her heels and she refused, it should be documented however, LPN-B stated there was, "No documentation to	F 314	status impacting risk and the care plan and my best day/ team sheet are updated to reflect interventions or changes in skin risk. Reoccurrence will be prevented by: Clinical Coordinator or designee auditing the care plan, assessment and team sheets to ensure all of the information is accurate. Staff will audit 10% of the residents each week to make sure all areas are matching and that the interventions are in place. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. The Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The 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 ______ B. WING ______	08/31/2016

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 314	Continued From page 27 support" they had been floated during the previous night or morning. When interviewed again on 8/31/16, at 1:56 p.m. LPN-B stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't. A facility Skin Risk Policy dated 8/2016, identified a directive to, "Implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care." Further, the policy provided general care guidelines for staff to follow which included, "Elevate heels off bed as indicated..."	F 314		

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 ______	08/31/2016

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 8/29/16, to 8/31/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Lake Minnetonka Shores was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time	F 156		9/30/16

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

Electronically Signed — 09/30/2016

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 ______	08/31/2016

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 156	Continued From page 1 of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy	F 156		

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 ______	08/31/2016

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 156	Continued From page 2 groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Non-Coverage for 1 of 3 residents (R93) reviewed for liability notices. Findings include: R93's progress note dated 7/13/16, identified R93 would be completing therapy and discharge back to assisted living on 7/15/16. R93 had, "No further recommendations for continued therapy."	F 156	Resident 93 was discharged prior to adequate notice given related to family and resident's wishes to discharge earlier than anticipated end date of therapy. Corrective Action as it applies to other residents: The policy and procedure for Medicare Denials was reviewed and is current. To prevent reoccurrence for other residents the criteria for denial for	

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 ______	08/31/2016

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 156	Continued From page 3 R93's medical record was reviewed. There was no evidence R93 had been provided a Notice of Medicare Non-Coverage (CMS-10123) as required when their Medicare coverage was ended. During interview on 8/31/16, at 3:55 p.m. licensed social worker (LSW)-A stated R93 admitted to the nursing home for therapy services under Medicare Part A coverage. R93 completed his therapy services and was originally planned to discharge on Saturday, 7/16/16, however the assisted living would not accept him on the weekend. LSW-A stated a decision was made with R93's family to move up his discharge to Friday, 7/15/16, instead. LSW-A stated R93 was not provided a Notice of Medicare Non-Coverage (CMS-10123) because R93, "Chose to go on his own wishes prior to the last day."	F 156	Medicare benefits is reviewed daily at IDT meetings. In-service for this group will be held the week of 9/26/2016. Specific training and tool kits were created for staff responsible for providing notices. Reoccurrence will be prevented by: Audits will be done weekly by the Resident Services Director (LSW) or designee. The audits will be reviewed monthly to check for criteria of discharge to make sure notices are given timely. Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Administrator will be responsible for compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157		10/7/16

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 ______	08/31/2016

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 4 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform the resident's physician of pertinent information about the resident's status after the resident fell for 1 of 2 residents (R148) reviewed for falls. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. The 5/23/16 admission Minimum Data Set identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. Comprehensive Data Collection form dated	F 157	Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and	

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 ______	08/31/2016

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 5

5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Neurological status noted weakness and a history of and risk for falls.

R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls.

The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait.

The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16 identified R146 was" Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was filled out by Physical Therapy-A.

A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R146 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via

F 157

timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention.

Reoccurrence will be prevented by:
a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.
b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends.
The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. Administrator will report audits to the QA Team. QA will determine frequency of audits
c. The Clinical Administrator will be responsible for ongoing compliance.

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 ______	08/31/2016

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 6 voicemail at 6:35 p.m. of the fall. A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "Pressure to stop bleeding" and "Cold compress to hematoma". The medical provider was notified by fax on 5/23/16 at 1:10 a.m. of the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall 79/49. Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16 at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration to the back/top of R148's head. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light. A Facility Facsimile Transmittal Form sent to the physician faxed on 5/23/16 which was hand written on the form. The form identified "6:00 p.m. while ambulating to dining room 'my knees gave	F 157		

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 ______	08/31/2016

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 7	F 157		

out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified "9:00 pm. Resident 'thought she could do it herself'' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked "noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R146 and R146 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was filled out by physical therapy assistant-A.

R148's Care Conference Summary dated 5/23/16, identified R148 "Had 2 falls on Sunday, did hit head". It also noted "Had increase in weakness over the weekend and increased shakiness." The summary noted "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148 progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD,

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 ______	08/31/2016

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		F 157		

Continued From page 8
"fall noted".

- 5/23/16 at 8:23 am titled care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box with observed on floor, "bleeding on R [right] cheek." Medical attention required, no;

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 ______	08/31/2016

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 9	F 157		

first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes from 5/19/16 to 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT-Therapist Progress & Discharge Summary dated 5/24/16, identified "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted "Skilled services provided since start of care included There ex [therapeutic exercises], gait training And pt education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R148) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on

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 ______	08/31/2016

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 10	F 157		

5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, with a change in status the MD should be notified.

When interviewed on 8/31/16, at 4:46 p.m. medical doctor (MD)-A stated a fax was received on 5/23/16 at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status. "We didn't know that she was bleeding." Notification received from the facility included a

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 ______	08/31/2016

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 11 routine fax to sign orders for therapy, and the next was a notification of her death. "Nowhere did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but "given her history you gotta wonder." Although R148 showed a change in her medical status after her fall and subsequent death on 5/23/16, the facility had not recognized and comprehensively assessed these medical changes and failed to contact the physician for possible medical interventions for R148. A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls. A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions.	F 157		

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 ______	08/31/2016

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 241	Continued From page 12	F 241		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified rising routine was consistently provided for 1 of 3 residents (R80) reviewed for dignity. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. During interview on 8/29/16, at 4:24 p.m. R80 stated she did not feel staff treated her with dignity because it seemed, "Like there's always a lag of time," in getting assistance with cares and dressing. R80 stated the staff often start helping her then, "Leave the room and not come back," so R80 has to, "Lay there on the bed waiting for someone to help finish dressing me." R80 stated this happens, "All the time," and it makes her feel, "Rejected and uncared for." On 8/31/16, at 7:54 a.m. R80 was in bed in her room with her call light turned on. Licensed practical nurse (LPN)-B entered the room and turned off R80's call light. LPN-B applied a cream to R80's legs and asked her, "Are you	F 241	Corrective Action: To correct the deficient practice for resident #80, LSW interviewed resident to make sure we have proper understanding of what time the resident would prefer to rise and go to bed. Weekly check-ins with Resident Services for this resident will occur to ensure resident needs are being met. Corrective Action as it applies to other residents: The policy and procedure for call light response and dignity were reviewed and are current. All resident preferences are assessed upon admission, minimally quarterly and as indicated with a change in request of services from family or resident. All staff are trained on timely response of call lights and meeting resident requests upon hire and minimally annually with annual training. An in-service will be provided to review the importance of resident preferences and Dignity policy during the week of October 3, 2016. This topic will be discussed at resident council upcoming in October as to resident preference and timeliness of services. Household residents will be interviewed by	10/7/16

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 ______	08/31/2016

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 241 Continued From page 13

ready to get up?" R80 stated she had, "Been waiting to get up," to which LPN-B stated she would inform the nursing assistant (NA) staff. At 7:57 a.m. R80 again turned on her call light outside the room. LPN-B entered the room and turned off the call light and told R80 the NA staff would be coming, "In a minute." LPN-B then applied a warm washcloth to R80's eyes and left the room.

At 8:25 a.m. R80 remained in bed without any assistance being offered to help her get up or ready for the day as she had requested. R80 stated she was, "Waiting on my aides [NA]," and had been waiting for help to get up, "since 7:30 [a.m.]." R80 stated having to wait this long for help had happened before, and it makes her feel, "Lonelier because I have to eat by myself [in the dining room]." At 8:29 a.m. (thirty five minutes after observation began) NA-A entered R80's room and helped her get dressed for the day. At 9:28 a.m. R80 was assisted out of her room to the dining room and seated at a table by herself, with only two other residents seated in the dining room at a different table. R80 was served breakfast alone in the dining room.

When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80 had complained about not being helped timely in the morning before to her, and residents sometimes have to wait for longer periods if they are short staffed because they are typically, "Really behind," then.

During interview on 8/31/16, at 10:03 a.m. LPN-B stated staff, "Try to get them [residents] as we can," and sometimes R80, "Has to wait a little bit" for her cares in the morning.

F 241

LSW to learn preference on what time the residents would like to get up and go to sleep each day. A committee has been formed to discuss ongoing staffing patterns in the morning/evening and how we can best meet our residents preferences.

Reoccurrence will be prevented by:
Weekly Audits will be done on 10% of the residents to ensure resident s preferences are being met when it comes to preferred wake times and the times they are going to bed. Residents preferred wake times will be added to NAR team sheets. Audits of timely response rates will also be conducted to ensure ongoing needs are being met timely.

The Correction will be monitored by:
a. The audits will be given to the Administrator for review.
b. Administrator will report audits to the QA Team. QA will determine frequency of audits
c. The 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 ______ B. WING ______	08/31/2016

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 241	Continued From page 14 When interviewed on 8/31/16, at 12:20 p.m. LPN clinical coordinator (LPN)-C stated residents should not have to wait for extended periods to be helped with cares adding, "We don't ever want anyone to wait a long period of time," because, "This is their home and they need to feel trust in us." A facility Dignity policy dated 12/2014, identified resident should be cared for, "In a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions to promote skin integrity for 1 of 4 residents (R80) reviewed for pressure ulcers. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's care plan dated 8/3/16, identified R80 had,	F 282	Corrective Action: To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected and staff involved were re-educated on resident plan of care. The care plan was reviewed and is current. The Team Sheet was updated to match Care Plan interventions. Corrective Action as it applies to other residents: The policy and procedure for care plan was reviewed and is current. All residents are assessed on admission and care plan initiated. All residents care plan	10/7/16

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 ______	08/31/2016

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 282	Continued From page 15 "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 9:52 a.m. licensed practical nurse (LPN)-B stated the care plan was used as an, "Overall guide on how to take care of that person," and staff were to, "Follow the care plan the way its supposed to be followed." When interviewed on 8/31/16, at 1:56 p.m. LPN-C stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't.	F 282	and My Best Day/assignment sheet are reviewed minimally quarterly and with change in status and updated with any changes. We will audit the team sheets to make sure the current team sheets match the care plan for each resident. When there is a change in care the Clinical Coordinators (or designee) will update the team sheets and the care plan. There will be an in-service regarding the process of updating of care plan and team sheets for all nursing the week of October 3, 2016. Reoccurrence will be prevented by: Weekly Audits will be completed by Clinical Coordinators. They will chose 10% of the residents each week to make sure care plans match team sheets and that the services indicated on the plan of care are being followed. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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 ______ B. WING ______	08/31/2016

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 282	Continued From page 16 A facility Care Plan Policy and Procedure dated 4/2016, identified a care plan was used to, "Ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible."	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess and monitor a significant change about a resident's status after the resident fell, for 1 of 2 residents (R148) reviewed for accidents. This resulted in actual harm for R148, after developing a cranial hematoma, laceration and died. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. R148's admission Minimum Data Set dated 5/23/16, identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days.	F 309	Resident #148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An in-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider	10/7/16

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 ______	08/31/2016

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 309		F 309		

Continued From page 17

R148's Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Further, the neurological status noted weakness and a history of and risk for falls.

R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls.

The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait.

The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16, identified R148 was "Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was completed by Physical Therapist (PT)-A.

A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R148 had a witnessed fall without injury. R148 was walking to the dining

team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention.

Reoccurrence will be prevented by:
a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.
b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends.

The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. Administrator will report audits to the QA Team. QA will determine frequency of audits
c. The Clinical Administrator will be responsible for ongoing compliance.

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 ______	08/31/2016

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 309	Continued From page 18	F 309		

room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via voicemail at 6:35 p.m. of the fall.

A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "pressure to stop bleeding" and "cold compress to hematoma." The medical provider was notified by fax on 5/23/16, at 1:10 a.m., 4 hours and 10 minutes after the injury from the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall was 79/49. The Fall Huddle Review Form dated 5/22/16 identified a drawing of the residents position in relation to other items. The picture identified R148's head was touching a dresser, which was next to the residents television.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16, at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry

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 ______	08/31/2016

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 309	Continued From page 19	F 309		

showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form was faxed to the the physician with a faxed date identified as 5/23/16, which was hand written on the form. The form identified: "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified: "9:00 pm. Resident 'thought she could do it herself' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked, "Noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

An undated facility Falls Follow Up Form for R148 was reviewed. The form lacked date or time of the occurrence, however identified long term interventions of resident changed to assist of one with all transfers, and therapy notified of increased weakness. Neuro at baseline and INR (international normalized ratio), a laboratory test for measurement of anticoagulants for blood clotting, was within normal limits. There was no date or time identified of when this form was completed for the long term interventions.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R148. R148 needed assistance of one for toileting, bed to chair/chair to bed transfers

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 ______	08/31/2016

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 309	Continued From page 20	F 309		

and sit to stand. A change was made to walking with assistance of one at all times. The form was completed by physical therapy assistant-A.

R146's Care Conference Summary dated 5/23/16, identified: "[R148] had 2 falls on Sunday, did hit head." It also noted: "Had increase in weakness over the weekend and increased shakiness." The summary noted: "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148's progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

- 5/23/16 at 8:23 am care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on

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 ______	08/31/2016

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 309	Continued From page 21	F 309		

back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box observed on floor and, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes on 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT - Therapist Progress & Discharge Summary dated 5/24/16, identified: "Pt [patient] passed away unexpectedly last night following

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 ______	08/31/2016

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 309	Continued From page 22	F 309		

decline over the past few days." It also noted: "Skilled services provided since start of care included There ex [therapeutic exercises], gait training and pt [patient] education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R146) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was

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 ____	08/31/2016

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 309	Continued From page 23	F 309		

unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, and with a change in status the medical doctor (MD) should be notified.

When interviewed on 8/31/16, at 4:46 p.m. MD-A stated a fax was received on 5/23/16, at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status and stated, "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. MD-A added, "No where did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but added, "Given her history you gotta wonder."

R148 was admitted to the facility on 5/18/16, and was independent with; toileting, transferring from bed to chair, sit to stand, walking in her room and only needed staff assistance of one, if ambulating more than 100 feet. R148 sustained 2 falls, on 5/23/16, following the fall on 5/23/16 at 9:00 p.m. R148 hit her head. R148 had changes in her medical status less than 24 hours after the fall. R148 complained she was not feeling very well, was gray in color, shaky and needed staff

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 ______	08/31/2016

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 309	Continued From page 24	F 309		

assistance with transfers and toileting even though she was previously independent with this. R148 also needed additional staff assistance for ambulation at all times, which was a change from assistance of one staff for long distances of 100+ feet, and had neurological changes in her pupil status 12 hours after her fall. Although R148 showed a change in her medical status after her fall on 5/22/16, the facility had not recognized and comprehensively reassess these medical changes and failed to contact the physician for possible medical interventions which resulted in actual harm for R148 who subsequently died.

A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls.

A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions.

F 314	483.25(c) TREATMENT/SVCS TO	F 314		10/7/16

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 ______	08/31/2016

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 314 SS=D

Continued From page 25

PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the risk of pressure ulcer formation for 1 of 4 residents (R80) reviewed for pressure ulcer care.

Findings include:

R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation.

R80's Skin Risk and Braden assessment, dated 7/20/16, identified R80 to have fragile skin and signs and symptoms of neuropathy with, "Tingling sensation of lower extremity or feet." Further, the assessment identified R80 was at, "Mild Risk" or developing pressure ulcers.

R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in

F 314

To correct this for resident #80, staff completed a Braden and Skin Risk Assessment to make the Care Plan correct and updated care plan/Team Sheets.

Corrective Action as it applies to other residents: The policy and procedure for skin risk and pressure ulcer prevention was reviewed and is current. To prevent reoccurrence for other residents we will pull a report of all pressure issues in Point Click Care and audit the Care Plan to make sure the proper instructions are on Team Sheets. An in-service will be held reviewing the Skin at Risk Policy to follow floating of heels and points of pressure. The Team Sheets will be reviewed to insure all areas of concern are addressed. All residents are assessed upon admission for skin risk and the care plan and my best day/ team sheet updated with interventions. All residents are assessed minimally quarterly and with change of

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 ______	08/31/2016

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 314 Continued From page 26

bed."

R80's most recent Body Audit dated 8/15/16, identified R80 had no current pressures and her heels were described as, "Clear."

During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft."

When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red."

During interview on 8/31/16, at 12:20 p.m. licensed practical nurse clinical coordinator (LPN)-B stated R80 was at, "Slight risk for pressure ulcers" because of her impaired mobility and incontinence. LPN-B stated she was unaware of any concerns for R80 concerning her heels which would cause them to be red, [I'm] not aware of anything wrong with her heels." LPN-B stated if staff attempted to float her heels and she refused, it should be documented however, LPN-B stated there was, "No documentation to

F 314

status impacting risk and the care plan and my best day/ team sheet are updated to reflect interventions or changes in skin risk.

Reoccurrence will be prevented by:
Clinical Coordinator or designee auditing the care plan, assessment and team sheets to ensure all of the information is accurate. Staff will audit 10% of the residents each week to make sure all areas are matching and that the interventions are in place.

The Correction will be monitored by:
a. The audits will be given to the Clinical Administrator for review.
b. The Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits.
c. The 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 ______ B. WING ______	08/31/2016

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 314	Continued From page 27	F 314		

support" they had been floated during the previous night or morning.

When interviewed again on 8/31/16, at 1:56 p.m. LPN-B stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't.

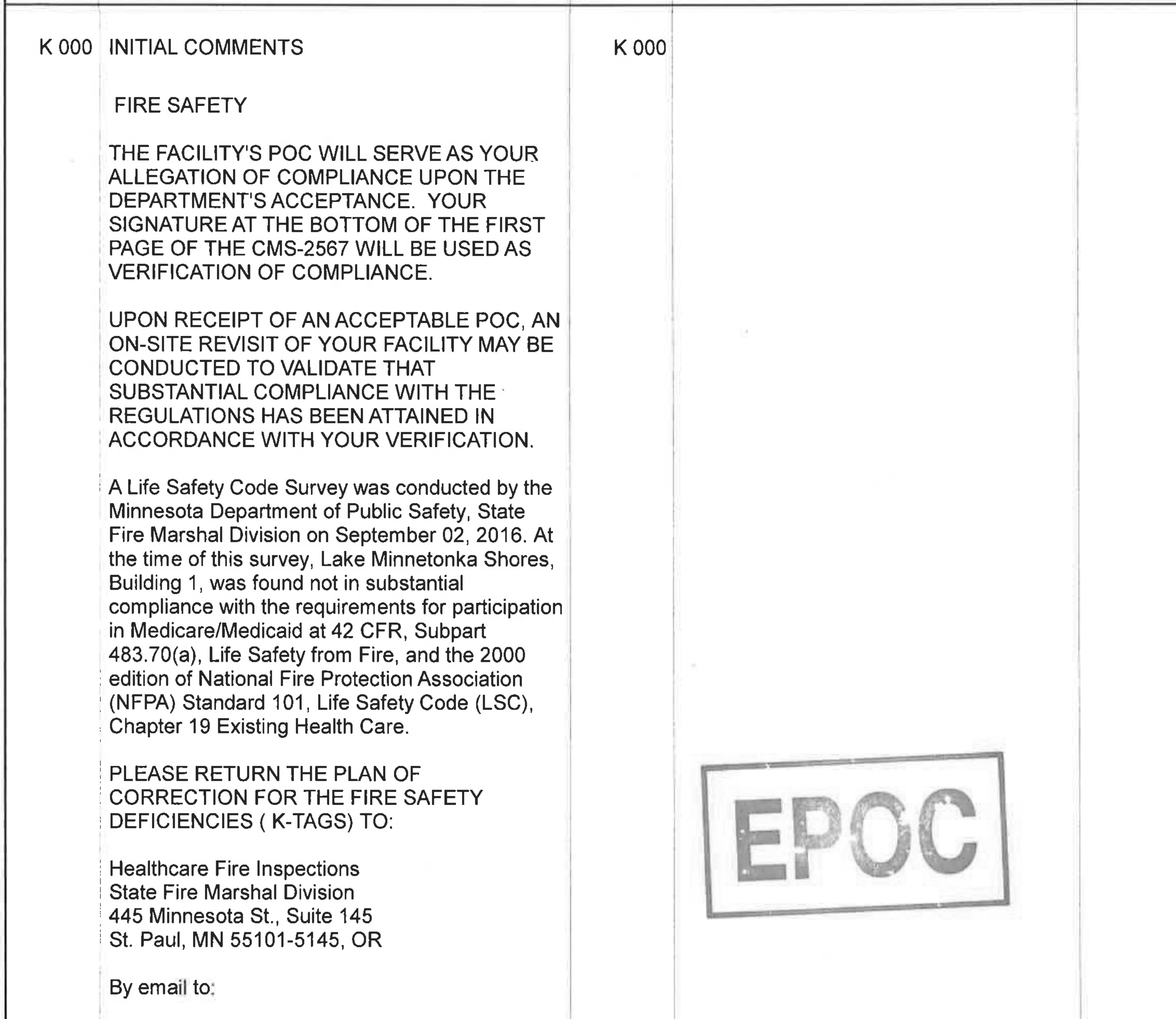
A facility Skin Risk Policy dated 8/2016, identified a directive to, "Implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care." Further, the policy provided general care guidelines for staff to follow which included, "Elevate heels off bed as indicated..."

F5210024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING **01** B. WING	**09/02/2016**

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 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 02, 2016. At the time of this survey, Lake Minnetonka Shores, Building 1, was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/30/2016

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 B. WING	09/02/2016

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 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 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 133 beds and had a census of 114 beds at the time of the survey.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING 01 B. WING ______	09/02/2016

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 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 114 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on September 02, 2016, observation revealed that the facility could not provide documentation for conducting a fire drill during the third shift in the second quarter of 2016. This deficient practice was confirmed by the Director of Maintenance at the time of inspection.	K 050	Electronic notifications have been implemented to ensure accurate fire drills are conducted once per shift per quarter. This has been implemented as of 9/6/16. Cory Gerber, the Director of Maintenance will update computer system in advance, and monitor electronic calendar notifications to prevent a reoccurrence of this deficiency.	9/6/16

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

F5210024

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	**09/02/2016**

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 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 02, 2016. At the time of this survey, Lake Minnetonka Shores, Building 1, was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/30/2016

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 02 - BLDG TWO B. WING	09/02/2016

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	K 000		

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 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 133 beds and had a census of 114 beds at the time of the survey.

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

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 ______	09/02/2016

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 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 114 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on September 02, 2016, observation revealed that the facility could not provide documentation for conducting a fire drill during the third shift in the second quarter of 2016. This deficient practice was confirmed by the Director of Maintenance at the time of inspection.	K 050	Electronic notifications have been implemented to ensure accurate fire drills are conducted once per shift per quarter. This has been implemented as of 9/6/16. Cory Gerber, the Director of Maintenance will update computer system in advance, and monitor electronic calendar notifications to prevent a reoccurrence of this deficiency.	9/6/16

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
September 21, 2016

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5210025

Dear Ms. Beaudot:

The above facility was surveyed on August 29, 2016 through August 31, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

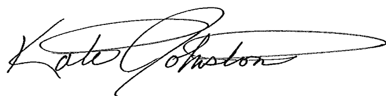
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000 10-03-16 gPN	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 28, 2016, through August 31, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 2	2 265		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: 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, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by:	2 265		10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 3	2 265		

Based on interview and document review, the facility failed to inform the resident's physician of pertinent information about the resident's status after the resident fell for 1 of 2 residents (R148) reviewed for falls.

Findings include:

R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. The 5/23/16 admission Minimum Data Set identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days.

Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Neurological status noted weakness and a history of and risk for falls.

R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls.

The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and

Resident # 148 expired on 5/23/2016

Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention.

Reoccurrence will be prevented by:
a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.
b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 4 left knee feeling like it would buckle with gait. The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16 identified R146 was" Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was filled out by Physical Therapy-A. A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R146 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via voicemail at 6:35 p.m. of the fall. A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "Pressure to stop bleeding" and "Cold compress to hematoma". The medical provider was notified by fax on 5/23/16 at 1:10 a.m. of the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall 79/49. Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16 at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last	2 265	building will be reviewing on the weekends. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Clinical Administrator will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 5	2 265		

neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration to the back/top of R148's head. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form sent to the physician faxed on 5/23/16 which was hand written on the form. The form identified "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified "9:00 pm. Resident 'thought she could do it herself" and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked "noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R146 and R146 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was filled out by physical therapy assistant-A.

R148's Care Conference Summary dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 6	2 265		

5/23/16, identified R148 "Had 2 falls on Sunday, did hit head". It also noted "Had increase in weakness over the weekend and increased shakiness." The summary noted "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148 progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

- 5/23/16 at 8:23 am titled care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 7	2 265		

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box with observed on floor, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes from 5/19/16 to 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT-Therapist Progress & Discharge Summary dated 5/24/16, identified "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted "Skilled services provided since start of care included There ex [therapeutic exercises], gait training And pt education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ___ B. WING ___	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 8 When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R148) changed, and needed assistance of one for all mobility (including transferring and ambulation). When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff. When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes,	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 9	2 265		

R148 had a change in status, with a change in status the MD should be notified.

When interviewed on 8/31/16, at 4:46 p.m. medical doctor (MD)-A stated a fax was received on 5/23/16 at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status. "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. "Nowhere did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but "given her history you gotta wonder."

Although R148 showed a change in her medical status after her fall and subsequent death on 5/23/16, the facility had not recognized and comprehensively assessed these medical changes and failed to contact the physician for possible medical interventions for R148.

A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls.

A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 10 review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff on ensuring the physician is notified timely of significant changes in resident condition, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions to promote skin integrity for 1 of 4 residents (R80) reviewed for pressure ulcers. Findings include:	2 565	To correct this for resident 80 staff completed a Braden and Skin Risk Assessment to make the Care Plan correct and update care plan/Team Sheets.	10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 565	Continued From page 11 R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 9:52 a.m. licensed practical nurse (LPN)-B stated the care plan was used as an, "Overall guide on how to take care of that person," and staff were to, "Follow the care plan the way its supposed to be followed."	2 565	Corrective Action as it applies to other residents: The policy and procedure for skin risk and pressure ulcer prevention was reviewed and is current. To prevent reoccurrence for other residents we will pull a report of all pressure issues in Point Click Care and audit the Care Plan to make sure the proper instructions are on Team Sheets. An In-service will be held reviewing the Skin at Risk Policy to follow floating of heels and points of pressure. The Team Sheets will be reviewed to insure all areas of concern are addressed. All residents are assessed upon admission for skin risk and the care plan and my best day/ team sheet updated with interventions. All residents are assessed minimally quarterly and with change of status impacting risk and the care plan and my best day/ team sheet are updated to reflect interventions or changes in skin risk. Reoccurrence will be prevented by: Clinical Coordinator or designee auditing the care plan, assessment and team sheets to ensure all of the information is accurate. Staff will audit 10% of the residents each week to make sure all areas are matching and that the interventions are in place. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. The Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The Administrator will be responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 565	Continued From page 12 When interviewed on 8/31/16, at 1:56 p.m. LPN-C stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't. A facility Care Plan Policy and Procedure dated 4/2016, identified a care plan was used to, "Ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about implementing the care plan and then audit cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565	compliance	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess and monitor a significant change about a resident's status after the resident fell, for 1 of 2 residents (R148) reviewed for accidents. This resulted in actual harm for R148, after developing a cranial hematoma, laceration and died. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. R148's admission Minimum Data Set dated 5/23/16, identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. R148's Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Further, the neurological status noted weakness and a history of and risk for falls. R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls. The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization	2 830	Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention. Reoccurrence will be prevented by: a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 14 for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait. The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16, identified R148 was "Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was completed by Physical Therapist (PT)-A. A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R148 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via voicemail at 6:35 p.m. of the fall. A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "pressure to stop bleeding" and "cold compress to hematoma." The medical provider was notified by fax on 5/23/16, at 1:10 a.m., 4 hours and 10 minutes after the injury from the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall was 79/49. The Fall Huddle Review Form dated 5/22/16 identified a drawing of the residents position in relation to other items. The picture identified R148's head was touching a	2 830	b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Clinical Administrator will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 15	2 830		

dresser, which was next to the residents television.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16, at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form was faxed to the the physician with a faxed date identified as 5/23/16, which was hand written on the form. The form identified: "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified: "9:00 pm. Resident 'thought she could do it herself' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked, "Noted" and signed by the physician on 5/23/16, and faxed back to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 16	2 830		

Continued From page 16

5/23/16, at 8:29 a.m.

An undated facility Falls Follow Up Form for R148 was reviewed. The form lacked date or time of the occurrence, however identified long term interventions of resident changed to assist of one with all transfers, and therapy notified of increased weakness. Neuro at baseline and INR (international normalized ratio), a laboratory test for measurement of anticoagulants for blood clotting, was within normal limits. There was no date or time identified of when this form was completed for the long term interventions.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R148. R148 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was completed by physical therapy assistant-A.

R146's Care Conference Summary dated 5/23/16, identified: "[R148] had 2 falls on Sunday, did hit head." It also noted: "Had increase in weakness over the weekend and increased shakiness." The summary noted: "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148's progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 17	2 830		

- 5/23/16 at 8:23 am care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box observed on floor and, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 18	2 830		

respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes on 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT - Therapist Progress & Discharge Summary dated 5/24/16, identified: "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted: "Skilled services provided since start of care included There ex [therapeutic exercises], gait training and pt [patient] education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R146) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 19	2 830		

notification would be acceptable, and the only time a call is warranted is when there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, and with a change in status the medical doctor (MD) should be notified.

When interviewed on 8/31/16, at 4:46 p.m. MD-A stated a fax was received on 5/23/16, at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status and stated, "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. MD-A added, "No where did we see a change in neuro status or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: _____ B. WING _____	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 20	2 830		

bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but added, "Given her history you gotta wonder."

R148 was admitted to the facility on 5/18/16, and was independent with; toileting, transferring from bed to chair, sit to stand, walking in her room and only needed staff assistance of one, if ambulating more than 100 feet. R148 sustained 2 falls, on 5/23/16, following the fall on 5/23/16 at 9:00 p.m. R148 hit her head. R148 had changes in her medical status less than 24 hours after the fall. R148 complained she was not feeling very well, was gray in color, shaky and needed staff assistance with transfers and toileting even though she was previously independent with this. R148 also needed additional staff assistance for ambulation at all times, which was a change from assistance of one staff for long distances of 100+ feet, and had neurological changes in her pupil status 12 hours after her fall. Although R148 showed a change in her medical status after her fall on 5/22/16, the facility had not recognized and comprehensively reassess these medical changes and failed to contact the physician for possible medical interventions which resulted in actual harm for R148 who subsequently died.

A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ________ B. WING ________	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 21 A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff to ensuring ongoing and consistent monitoring of any changes in condition are completed with medical intervention, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 900	Continued From page 22 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the risk of pressure ulcer formation for 1 of 4 residents (R80) reviewed for pressure ulcer care. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's Skin Risk and Braden assessment, dated 7/20/16, identified R80 to have fragile skin and signs and symptoms of neuropathy with, "Tingling sensation of lower extremity or feet." Further, the assessment identified R80 was at, "Mild Risk" or developing pressure ulcers. R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." R80's most recent Body Audit dated 8/15/16, identified R80 had no current pressures and her heels were described as, "Clear." During observation of morning care on 8/31/16, at	2 900	To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected and staff involved were re-educated on resident plan of care. The care plan was reviewed and is current. The Team Sheet was updated to match Care Plan interventions. Corrective Action as it applies to other residents: The policy and procedure for care plan was reviewed and is current. All residents are assessed on admission and care plan initiated. All residents care plan and My Best day/ assignment sheet are reviewed minimally quarterly and with change in status and updated with any changes. To prevent reoccurrence for other residents we will audit the team sheets to make sure the current team sheets match the care plan for each resident. When there is a change in care the clinical coordinators (or designee) will update the team sheets and the care plan. There will be an in-service regarding the process of updating of care plan and team sheets for all nursing the week of October 3, 2016. Reoccurrence will be prevented by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 900	Continued From page 23 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 12:20 p.m. licensed practical nurse clinical coordinator (LPN)-B stated R80 was at, "Slight risk for pressure ulcers" because of her impaired mobility and incontinence. LPN-B stated she was unaware of any concerns for R80 concerning her heels which would cause them to be red, [I'm] not aware of anything wrong with her heels." LPN-B stated if staff attempted to float her heels and she refused, it should be documented however, LPN-B stated there was, "No documentation to support" they had been floated during the previous night or morning. When interviewed again on 8/31/16, at 1:56 p.m. LPN-B stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't.	2 900	Weekly audits will be done by Clinical Coordinators. They will chose 10% of the residents each week to make sure care plans match team sheets and that the services indicated on the plan of care are being followed. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 900	Continued From page 24	2 900		

A facility Skin Risk Policy dated 8/2016, identified a directive to, "Implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care." Further, the policy provided general care guidelines for staff to follow which included, "Elevate heels off bed as indicated..."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about implementing the care plan to prevent pressure ulcer development, and then audit cares to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights	21800		9/30/16

Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21800	Continued From page 25 accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Non-Coverage for 1 of 3 residents (R93) reviewed for liability notices. Findings include: R93's progress note dated 7/13/16, identified R93 would be completing therapy and discharge back to assisted living on 7/15/16. R93 had, "No further recommendations for continued therapy." R93's medical record was reviewed. There was no evidence R93 had been provided a Notice of Medicare Non-Coverage (CMS-10123) as required when their Medicare coverage was ended. During interview on 8/31/16, at 3:55 p.m. licensed social worker (LSW)-A stated R93 admitted to the nursing home for therapy services under Medicare Part A coverage. R93 completed his therapy services and was originally planned to	21800	Resident 93 was discharged prior to adequate notice given related to family and resident's wishes to discharge earlier than anticipated end date of therapy. Corrective Action as it applies to other residents: The policy and procedure for Medicare Denials was reviewed and is current. To prevent reoccurrence for other residents the criteria for denial for Medicare benefits is reviewed daily at IDT meetings. This in-service for this group will be held the week of 9/26/2016. Specific training and tool kits were created for staff responsible for providing notices. Reoccurrence will be prevented by: Audits will be done weekly by the Resident Services Director (LSW) or designee. The audits will be reviewed monthly to check for criteria of discharge to make sure notices are given timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21800	Continued From page 26 discharge on Saturday, 7/16/16, however the assisted living would not accept him on the weekend. LSW-A stated a decision was made with R93's family to move up his discharge to Friday, 7/15/16, instead. LSW-A stated R93 was not provided a Notice of Medicare Non-Coverage (CMS-10123) because R93, "Chose to go on his own wishes prior to the last day." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about providing Medicare notices of non-coverage timely, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800	Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Administrator will be responsible for compliance.	
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified rising routine was consistently provided for 1 of 3 residents (R80) reviewed for dignity. Findings include: R80's quarterly Minimum Data Set (MDS) dated	21805	To correct the deficient practice for resident #80 LSW interviewed resident to make sure we have proper understanding of what time the resident would prefer to rise and go to bed. Weekly check-ins with resident services for this resident will occur to ensure resident needs are being met ongoing.	10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21805	Continued From page 27 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. During interview on 8/29/16, at 4:24 p.m. R80 stated she did not feel staff treated her with dignity because it seemed, "Like there's always a lag of time," in getting assistance with cares and dressing. R80 stated the staff often start helping her then, "Leave the room and not come back," so R80 has to, "Lay there on the bed waiting for someone to help finish dressing me." R80 stated this happens, "All the time," and it makes her feel, "Rejected and uncared for." On 8/31/16, at 7:54 a.m. R80 was in bed in her room with her call light turned on. Licensed practical nurse (LPN)-B entered the room and turned off R80's call light. LPN-B applied a cream to R80's legs and asked her, "Are you ready to get up?" R80 stated she had, "Been waiting to get up," to which LPN-B stated she would inform the nursing assistant (NA) staff. At 7:57 a.m. R80 again turned on her call light outside the room. LPN-B entered the room and turned off the call light and told R80 the NA staff would be coming, "In a minute." LPN-B then applied a warm washcloth to R80's eyes and left the room. At 8:25 a.m. R80 remained in bed without any assistance being offered to help her get up or ready for the day as she had requested. R80 stated she was, "Waiting on my aides [NA]," and had been waiting for help to get up, "since 7:30 [a.m.]." R80 stated having to wait this long for help had happened before, and it makes her feel, "Lonelier because I have to eat by myself [in the dining room]." At 8:29 a.m. (thirty five minutes after observation began) NA-A entered R80's	21805	Corrective Action as it applies to other residents: The policy and procedure for call light response and dignity were reviewed and are current. All resident preferences are assessed upon admission, minimally quarterly and as indicated with a change in request of services from family or resident. All staff are trained on timely response of call lights and meeting resident requests upon hire and minimally annually with annual training. We will do an in-service to review the importance of resident preferences and Dignity policy during the week of October 3, 2016. This topic will be discussed at resident council upcoming in October as to resident preference and timeliness of services. Household residents will be interviewed by LSW to learn preference on what time the residents would like to get up and go to sleep each day. A Committee has been formed to discuss on going staffing patterns in the morning/evening and how we can best meet our residents preferences. Reoccurrence will be prevented by: Weekly audits will be done on 10% of the residents to ensure resident s preferences are being met when it comes to preferred wake times and the times they are going to bed. Residents preferred wake times will be added to NAR team sheets. Audits of timely response rates will also be conducted to ensure ongoing needs are being met timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21805	Continued From page 28 room and helped her get dressed for the day. At 9:28 a.m. R80 was assisted out of her room to the dining room and seated at a table by herself, with only two other residents seated in the dining room at a different table. R80 was served breakfast alone in the dining room. When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80 had complained about not being helped timely in the morning before to her, and residents sometimes have to wait for longer periods if they are short staffed because they are typically, "Really behind," then. During interview on 8/31/16, at 10:03 a.m. LPN-B stated staff, "Try to get them [residents] as we can," and sometimes R80, "Has to wait a little bit" for her cares in the morning. When interviewed on 8/31/16, at 12:20 p.m. LPN clinical coordinator (LPN)-C stated residents should not have to wait for extended periods to be helped with cares adding, "We don't ever want anyone to wait a long period of time," because, "This is their home and they need to feel trust in us." A facility Dignity policy dated 12/2014, identified resident should be cared for, "In a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could inservice staff about ensuring cares are initiated and complete timely for each resident, then complete audits of care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21805	The Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21805	Continued From page 29 (21) days.	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 28, 2016, through August 31, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 2	2 265		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: 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, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by:	2 265		10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ___ B. WING ___	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 3 Based on interview and document review, the facility failed to inform the resident's physician of pertinent information about the resident's status after the resident fell for 1 of 2 residents (R148) reviewed for falls. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. The 5/23/16 admission Minimum Data Set identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Neurological status noted weakness and a history of and risk for falls. R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls. The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and	2 265	Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention. Reoccurrence will be prevented by: a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family. b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 4 left knee feeling like it would buckle with gait. The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16 identified R146 was" Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was filled out by Physical Therapy-A. A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R146 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via voicemail at 6:35 p.m. of the fall. A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "Pressure to stop bleeding" and "Cold compress to hematoma". The medical provider was notified by fax on 5/23/16 at 1:10 a.m. of the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall 79/49. Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16 at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last	2 265	building will be reviewing on the weekends. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Clinical Administrator will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 5	2 265		

neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration to the back/top of R148's head. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form sent to the physician faxed on 5/23/16 which was hand written on the form. The form identified "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified "9:00 pm. Resident 'thought she could do it herself'' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked "noted" and signed by the physician on 5/23/16, and faxed back to the facility on 5/23/16, at 8:29 a.m.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R146 and R146 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was filled out by physical therapy assistant-A.

R148's Care Conference Summary dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 6	2 265		

5/23/16, identified R148 "Had 2 falls on Sunday, did hit head". It also noted "Had increase in weakness over the weekend and increased shakiness." The summary noted "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148 progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

- 5/23/16 at 8:23 am titled care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ________ B. WING ________	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 7	2 265		

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box with observed on floor, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes from 5/19/16 to 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT-Therapist Progress & Discharge Summary dated 5/24/16, identified "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted "Skilled services provided since start of care included There ex [therapeutic exercises], gait training And pt education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 8 When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R148) changed, and needed assistance of one for all mobility (including transferring and ambulation). When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax notification would be acceptable, and the only time a call is warranted is when there there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff. When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes,	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 9	2 265		

R148 had a change in status, with a change in status the MD should be notified.

When interviewed on 8/31/16, at 4:46 p.m. medical doctor (MD)-A stated a fax was received on 5/23/16 at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status. "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. "Nowhere did we see a change in neuro status or the bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but "given her history you gotta wonder."

Although R148 showed a change in her medical status after her fall and subsequent death on 5/23/16, the facility had not recognized and comprehensively assessed these medical changes and failed to contact the physician for possible medical interventions for R148.

A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls.

A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 265	Continued From page 10 review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff on ensuring the physician is notified timely of significant changes in resident condition, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions to promote skin integrity for 1 of 4 residents (R80) reviewed for pressure ulcers. Findings include:	2 565	To correct this for resident 80 staff completed a Braden and Skin Risk Assessment to make the Care Plan correct and update care plan/Team Sheets.	10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 565	Continued From page 11 R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." During observation of morning care on 8/31/16, at 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 9:52 a.m. licensed practical nurse (LPN)-B stated the care plan was used as an, "Overall guide on how to take care of that person," and staff were to, "Follow the care plan the way its supposed to be followed."	2 565	Corrective Action as it applies to other residents: The policy and procedure for skin risk and pressure ulcer prevention was reviewed and is current. To prevent reoccurrence for other residents we will pull a report of all pressure issues in Point Click Care and audit the Care Plan to make sure the proper instructions are on Team Sheets. An In-service will be held reviewing the Skin at Risk Policy to follow floating of heels and points of pressure. The Team Sheets will be reviewed to insure all areas of concern are addressed. All residents are assessed upon admission for skin risk and the care plan and my best day/ team sheet updated with interventions. All residents are assessed minimally quarterly and with change of status impacting risk and the care plan and my best day/ team sheet are updated to reflect interventions or changes in skin risk. Reoccurrence will be prevented by: Clinical Coordinator or designee auditing the care plan, assessment and team sheets to ensure all of the information is accurate. Staff will audit 10% of the residents each week to make sure all areas are matching and that the interventions are in place. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. The Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The Administrator will be responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 565	Continued From page 12 When interviewed on 8/31/16, at 1:56 p.m. LPN-C stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't. A facility Care Plan Policy and Procedure dated 4/2016, identified a care plan was used to, "Ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about implementing the care plan and then audit cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565	compliance	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00271	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/31/2016

NAME OF PROVIDER OR SUPPLIER: **LAKE MINNETONKA SHORES**

STREET ADDRESS, CITY, STATE, ZIP CODE: **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) COMPLETE DATE
2 830	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess and monitor a significant change about a resident's status after the resident fell, for 1 of 2 residents (R148) reviewed for accidents. This resulted in actual harm for R148, after developing a cranial hematoma, laceration and died. Findings include: R148's Admission Record sheet (undated) identified she was admitted to the facility on 5/18/16 with diagnoses of end stage renal disease, hypo tension, difficulty walking and a history of falls. R148's admission Minimum Data Set dated 5/23/16, identified R148 was on an anticoagulant medication (blood thinner), and had received the medication in the last 6 days. R148's Comprehensive Data Collection form dated 5/18/16, identified R148 was oriented to person, place and time, with level of consciousness as alert. Further, the neurological status noted weakness and a history of and risk for falls. R148's Individual Resident Care Plan dated 5/18/16, identified R148 was independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was alert and oriented. The care plan failed to address the risk for falls. The Physical Therapy (PT) Plan of Care dated 5/18/16, identified muscle weakness and difficulty in walking as the treatment diagnosis, with a start of care as 5/18/16. It also noted hospitalization	2 830	Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures for assessment and provider notification was reviewed and is current. All residents are assessed upon admission, minimally quarterly and as needed with change of condition. All residents with change of condition are reviewed with IDT daily and physicians updated timely as per clinical indications and per policy. The facility EMR also alerts nurses to documentation and report of NARs to potential change in status each shift. An In-service for nursing staff will be presented during the week of 10/3/2016 related to recognition and assessment of status change and timely notification of physician/ provider team including information to be reported. The information presented will review the policy on reporting Change of Condition and Policy on Falls. At this in-service staff will review eInteract tools, and the reporting of a Significant Change progress note. This will ensure ongoing and consistent monitoring of any change in condition is completed with medical intervention. Reoccurrence will be prevented by: a. Audits for significant change will be completed in daily IDT meeting. All falls will be reviewed for significant change. Policy will be followed for proper notification of provider, Administrator, and family.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 14 for falls and weakness, with three falls in the past month. R148 was noted to have complaints of weakness, fatigue and impaired balance impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and independently. R148 noted significant fatigue and left knee feeling like it would buckle with gait. The facility Therapy to Nursing Functional Maintenance Program form dated 5/18/16, identified R148 was "Independent Toilet, Bed to Chair/Chair to Bed, Sit to Stand." The form also identified under Walking, "Independent walking in room, A1 [assist of 1] longer distances [100+ feet] to all destinations." This form was completed by Physical Therapist (PT)-A. A Resident Occurrence Report dated 5/22/16, at 6:00 p.m. identified R148 had a witnessed fall without injury. R148 was walking to the dining room, knees gave out, and was lowered to the floor by staff. Medical provider was notified via voicemail at 6:35 p.m. of the fall. A Resident Occurrence Report dated 5/22/16, at 9:00 p.m. identified R148 was observed on the floor, noting a fall with injury, including hematoma and laceration to the back/top of head. The report noted medical attention was required, including "pressure to stop bleeding" and "cold compress to hematoma." The medical provider was notified by fax on 5/23/16, at 1:10 a.m., 4 hours and 10 minutes after the injury from the fall. R148 identified she hit her head, and her head hurt, and was holding her head with one hand. BP noted after the fall was 79/49. The Fall Huddle Review Form dated 5/22/16 identified a drawing of the residents position in relation to other items. The picture identified R148's head was touching a	2 830	b. 24 hour report will be reviewed daily by Clinical Coordinators to check for change in condition. The nurse in charge of the building will be reviewing on the weekends. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Clinical Administrator will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 15	2 830		

dresser, which was next to the residents television.

Review of the facility Neuro Check Flow sheet (a monitoring tool used to identify changes in neurological symptom changes), dated 5/22/16 from 9:00 pm thru 5/23/16 at 1:00 p.m. identified no changes in neurological status from 5/22/16 at 9:00 p.m. thru 5/23/16 at 5:00 a.m. The sheet identified on 5/23/16, at 9:00 a.m. and 1:00 p.m. R148's right and left pupils were slow to respond but identified there were no changes from last neuro check even though R148's pupils were slow to respond on these two separate occasions at 9:00 a.m. and 1:00 p.m., 12 hours after R148 fell hitting her head resulting in a hematoma and laceration. There was another entry on the Neuro Check Flow sheet after the 1:00 p.m. notation but there was no date identified (blank) and no specific time identified but just "PM". This entry showed no changes, and pupils were equal and reactive to light.

A Facility Facsimile Transmittal Form was faxed to the the physician with a faxed date identified as 5/23/16, which was hand written on the form. The form identified: "6:00 p.m. while ambulating to dining room 'my knees gave out'. NAR [nursing assistant registered] caught her and lowered her to a sitting position on floor." It also identified: "9:00 pm. Resident 'thought she could do it herself' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79/49. It was then 106/74 then 135/87..." There was no further data on the form to the physician following the ellipsis. This form was marked, "Noted" and signed by the physician on 5/23/16, and faxed back to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ________ B. WING ________	08/31/2016

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) COMPLETE DATE
2 830		2 830		

Continued From page 16

5/23/16, at 8:29 a.m.

An undated facility Falls Follow Up Form for R148 was reviewed. The form lacked date or time of the occurrence, however identified long term interventions of resident changed to assist of one with all transfers, and therapy notified of increased weakness. Neuro at baseline and INR (international normalized ratio), a laboratory test for measurement of anticoagulants for blood clotting, was within normal limits. There was no date or time identified of when this form was completed for the long term interventions.

A Therapy to Nursing Functional Maintenance Program dated 5/23/16, identified a change in status for R148. R148 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to walking with assistance of one at all times. The form was completed by physical therapy assistant-A.

R146's Care Conference Summary dated 5/23/16, identified: "[R148] had 2 falls on Sunday, did hit head." It also noted: "Had increase in weakness over the weekend and increased shakiness." The summary noted: "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend as is now SBA [stand by assist] with FWW [four wheeled walker]. Balance score puts resident in moderate risk for falls. Resident is SBA [stand by assist] for dressing/toileting."

Review of R148's progress notes dated 5/18/16, through 5/24/16, identified the following:

- 5/23/16 at 10:03 a.m. Fax received from MD, "fall noted".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 17	2 830		

- 5/23/16 at 8:23 am care conference summary, identified "Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a decline over the weekend and is not SBA [stand by assist] with FWW [four wheeled walker]."

- 5/23/16 at 12:47 p.m. by RN-B "Resident thought she could do it herself and ambulated to bathroom where she fell in the doorway. Resident landed on her back after hitting her head on built in dresser on way down. Put in bed with call light close at hand. Close monitor." Injury description was "Hit back/top of head. Bleeding and bump as result."

- 5/23/16 at 4:16 p.m. by LPN-A "Laceration on back of head dry, no infection noted."

- 5/23/16 at 6:16 p.m. by LPN-A "Res [resident] very weak and shaky today. Stayed in bed all shift, had room tray for dinner, appetite poor. Will cont [continue] to monitor."

-5/23/16 at 22:26 p.m. by LPN-A "Res [resident] roommate called out for a nurse from the hallway. She heard a loud crash that woke her up. Writer entered the room and found res [resident] lying face down, unresponsive. Res [resident] was rolled to her back and sternal rub tried. Resp [respirations] absent, pulse absent, res [resident] DNR/DNI."

Review of the facility Resident Occurrence Report dated 5/23/16, at 9:45 p.m. identified a check mark on box observed on floor and, "bleeding on R [right] cheek." Medical attention required, no; first aid required, no; witness, no. The form identified R148 was unconscious, unable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 18	2 830		

respond verbally and "res [resident] had expired." The physician was notified on 5/23/16 at 11:00 p.m.

Review of the PT Daily Treatment Notes on 5/23/16 identified the following:

5/23/16: "PTA [physical therapy assistant] alerted nursing of pt [patient] grey coloring, weakness and shakiness. Due to pt increased weakness got a w/c [wheelchair] for pt." It also noted "Pt very weak after 2nd fall. Pt shaky even with voice in speaking."

The PT - Therapist Progress & Discharge Summary dated 5/24/16, identified: "Pt [patient] passed away unexpectedly last night following decline over the past few days." It also noted: "Skilled services provided since start of care included There ex [therapeutic exercises], gait training and pt [patient] education which improved patient's abilities in Amb [ambulation], transfers and ADLs prior to functional decline leading up to pt passing away."

When interviewed on 8/31/16, at 2:09 p.m. rehab program manager (RPM) stated R148 was receiving therapy from 5/18/16, through 5/23/16. On 5/18/16, R148 was assessed as being independent, and when ambulating all longer distances was to have assist of one. On 5/23/16, the resident (R146) changed, and needed assistance of one for all mobility (including transferring and ambulation).

When interviewed on 8/31/16, at 2:29 p.m. registered nurse (RN)-B stated after the fall on 5/22/16, R148 had a wound on her head. Staff were expected to notify the physician and start neuro's, which they did. RN-B stated a fax

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 19	2 830		

notification would be acceptable, and the only time a call is warranted is when there was a change in cognition or a change in neuro's or when medical attention from the emergency room is required. The documentation identified (R148) had a hematoma with some bleeding. This was documented in the record and the physician would be called only if the bleeding did not stop. At 2:43 p.m. the director of nursing (DON) entered and stated a physician would not need to be called unless staff were unable to stop the bleeding, adding this is what the physician would expect from the staff.

When interviewed on 8/31/16, at 3:22 p.m. licensed practical nurse (LPN)-A stated he was unsure if R148 had any change in status. After reviewing the notes, LPN-A stated he would definitely notify the physician. However, LPN-A was unable to locate any notification made to the physician on 5/23/16, following the fall with a hematoma and laceration on 5/22/16, and complaints of not feeling well on 5/23/16. LPN-A also stated from reading the progress notes, R148 had a change in status, and with a change in status the medical doctor (MD) should be notified.

When interviewed on 8/31/16, at 4:46 p.m. MD-A stated a fax was received on 5/23/16, at 1:05 a.m. at the office, but nobody was in the office to receive it at that time. The fax was reviewed by her colleague on 5/23/16. The fax identified R148 had a bump on the head. MD-A denied any knowledge of a change in status and stated, "We didn't know that she was bleeding." Notification received from the facility included a routine fax to sign orders for therapy, and the next was a notification of her death. MD-A added, "No where did we see a change in neuro status or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ____ B. WING ____	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 20	2 830		

bleeding." MD-A stated there was a failure in communication, and it appeared R148 had a decline in status, not necessarily a head bleed, but added, "Given her history you gotta wonder."

R148 was admitted to the facility on 5/18/16, and was independent with; toileting, transferring from bed to chair, sit to stand, walking in her room and only needed staff assistance of one, if ambulating more than 100 feet. R148 sustained 2 falls, on 5/23/16, following the fall on 5/23/16 at 9:00 p.m. R148 hit her head. R148 had changes in her medical status less than 24 hours after the fall. R148 complained she was not feeling very well, was gray in color, shaky and needed staff assistance with transfers and toileting even though she was previously independent with this. R148 also needed additional staff assistance for ambulation at all times, which was a change from assistance of one staff for long distances of 100+ feet, and had neurological changes in her pupil status 12 hours after her fall. Although R148 showed a change in her medical status after her fall on 5/22/16, the facility had not recognized and comprehensively reassess these medical changes and failed to contact the physician for possible medical interventions which resulted in actual harm for R148 who subsequently died.

A facility policy dated as reviewed on 2/16, Change of Condition Physician Notification Policy, indicated staff was to notify the physician any time there was a significant change in condition. It also directed staff to document in the medical record the time called, the person spoken to, what was reported and their response if any. The policy included a "list of possible examples of what should be reported", which identified any injury requiring first aid, and any falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 830	Continued From page 21 A facility policy dated as reviewed 2/16, Fall Prevention and Management Program Policy review date 2/16, identified with minor head trauma or unwitnessed fall where the resident is not able to state if they hit their head, staff was to alert the physician or nurse practitioner with any changes. It also directed staff to make an entry into the medical record including patient appearance at the time of discovery, patient response to event, evidence of injury, location, medical provider notification, responsible party notification, and nursing actions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff to ensuring ongoing and consistent monitoring of any changes in condition are completed with medical intervention, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 900	Continued From page 22 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the risk of pressure ulcer formation for 1 of 4 residents (R80) reviewed for pressure ulcer care. Findings include: R80's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was at risk for pressure ulcer formation. R80's Skin Risk and Braden assessment, dated 7/20/16, identified R80 to have fragile skin and signs and symptoms of neuropathy with, "Tingling sensation of lower extremity or feet." Further, the assessment identified R80 was at, "Mild Risk" or developing pressure ulcers. R80's care plan dated 8/3/16, identified R80 had, "Limited physical mobility in bed," and R80 had, "Potential for alteration in skin integrity." The care plan directed staff to, "Keep heels elevated in bed." R80's most recent Body Audit dated 8/15/16, identified R80 had no current pressures and her heels were described as, "Clear." During observation of morning care on 8/31/16, at	2 900	To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected and staff involved were re-educated on resident plan of care. The care plan was reviewed and is current. The Team Sheet was updated to match Care Plan interventions. Corrective Action as it applies to other residents: The policy and procedure for care plan was reviewed and is current. All residents are assessed on admission and care plan initiated. All residents care plan and My Best day/ assignment sheet are reviewed minimally quarterly and with change in status and updated with any changes. To prevent reoccurrence for other residents we will audit the team sheets to make sure the current team sheets match the care plan for each resident. When there is a change in care the clinical coordinators (or designee) will update the team sheets and the care plan. There will be an in-service regarding the process of updating of care plan and team sheets for all nursing the week of October 3, 2016. Reoccurrence will be prevented by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 900	Continued From page 23 8:29 a.m. R80 was laying in her room in bed. Nursing assistant (NA)-A pulled back R80's bedding exposing R80's legs and feet. R80's heels were not being floated with any devices or pillows, instead they were directly on the mattress. R80 stated, "My heel hurts," and the back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 was assisted to the bathroom and NA-A stated R80 reddened heel, "Kind of feels soft." When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80's heels were not being floated when she removed her bedding and her right heel was reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when she would assist her with morning cares. Further, NA-A stated R80's heels have been red in the morning before when they are not floated, "Their usually red." During interview on 8/31/16, at 12:20 p.m. licensed practical nurse clinical coordinator (LPN)-B stated R80 was at, "Slight risk for pressure ulcers" because of her impaired mobility and incontinence. LPN-B stated she was unaware of any concerns for R80 concerning her heels which would cause them to be red, [I'm] not aware of anything wrong with her heels." LPN-B stated if staff attempted to float her heels and she refused, it should be documented however, LPN-B stated there was, "No documentation to support" they had been floated during the previous night or morning. When interviewed again on 8/31/16, at 1:56 p.m. LPN-B stated R80's heels should have been floated while she was in bed, or the nursing staff should have documented the reason why they weren't.	2 900	Weekly audits will be done by Clinical Coordinators. They will chose 10% of the residents each week to make sure care plans match team sheets and that the services indicated on the plan of care are being followed. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
2 900	Continued From page 24 A facility Skin Risk Policy dated 8/2016, identified a directive to, "Implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care." Further, the policy provided general care guidelines for staff to follow which included, "Elevate heels off bed as indicated..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about implementing the care plan to prevent pressure ulcer development, and then audit cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable	21800		9/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ________ B. WING ________	08/31/2016

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) COMPLETE DATE
21800	Continued From page 25 accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Non-Coverage for 1 of 3 residents (R93) reviewed for liability notices. Findings include: R93's progress note dated 7/13/16, identified R93 would be completing therapy and discharge back to assisted living on 7/15/16. R93 had, "No further recommendations for continued therapy." R93's medical record was reviewed. There was no evidence R93 had been provided a Notice of Medicare Non-Coverage (CMS-10123) as required when their Medicare coverage was ended. During interview on 8/31/16, at 3:55 p.m. licensed social worker (LSW)-A stated R93 admitted to the nursing home for therapy services under Medicare Part A coverage. R93 completed his therapy services and was originally planned to	21800	Resident 93 was discharged prior to adequate notice given related to family and resident's wishes to discharge earlier than anticipated end date of therapy. Corrective Action as it applies to other residents: The policy and procedure for Medicare Denials was reviewed and is current. To prevent reoccurrence for other residents the criteria for denial for Medicare benefits is reviewed daily at IDT meetings. This in-service for this group will be held the week of 9/26/2016. Specific training and tool kits were created for staff responsible for providing notices. Reoccurrence will be prevented by: Audits will be done weekly by the Resident Services Director (LSW) or designee. The audits will be reviewed monthly to check for criteria of discharge to make sure notices are given timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21800	Continued From page 26 discharge on Saturday, 7/16/16, however the assisted living would not accept him on the weekend. LSW-A stated a decision was made with R93's family to move up his discharge to Friday, 7/15/16, instead. LSW-A stated R93 was not provided a Notice of Medicare Non-Coverage (CMS-10123) because R93, "Chose to go on his own wishes prior to the last day." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about providing Medicare notices of non-coverage timely, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800	Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The Administrator will be responsible for compliance.	
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified rising routine was consistently provided for 1 of 3 residents (R80) reviewed for dignity. Findings include: R80's quarterly Minimum Data Set (MDS) dated	21805	To correct the deficient practice for resident #80 LSW interviewed resident to make sure we have proper understanding of what time the resident would prefer to rise and go to bed. Weekly check-ins with resident services for this resident will occur to ensure resident needs are being met ongoing.	10/7/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21805	Continued From page 27 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. During interview on 8/29/16, at 4:24 p.m. R80 stated she did not feel staff treated her with dignity because it seemed, "Like there's always a lag of time," in getting assistance with cares and dressing. R80 stated the staff often start helping her then, "Leave the room and not come back," so R80 has to, "Lay there on the bed waiting for someone to help finish dressing me." R80 stated this happens, "All the time," and it makes her feel, "Rejected and uncared for." On 8/31/16, at 7:54 a.m. R80 was in bed in her room with her call light turned on. Licensed practical nurse (LPN)-B entered the room and turned off R80's call light. LPN-B applied a cream to R80's legs and asked her, "Are you ready to get up?" R80 stated she had, "Been waiting to get up," to which LPN-B stated she would inform the nursing assistant (NA) staff. At 7:57 a.m. R80 again turned on her call light outside the room. LPN-B entered the room and turned off the call light and told R80 the NA staff would be coming, "In a minute." LPN-B then applied a warm washcloth to R80's eyes and left the room. At 8:25 a.m. R80 remained in bed without any assistance being offered to help her get up or ready for the day as she had requested. R80 stated she was, "Waiting on my aides [NA]," and had been waiting for help to get up, "since 7:30 [a.m.]." R80 stated having to wait this long for help had happened before, and it makes her feel, "Lonelier because I have to eat by myself [in the dining room]." At 8:29 a.m. (thirty five minutes after observation began) NA-A entered R80's	21805	Corrective Action as it applies to other residents: The policy and procedure for call light response and dignity were reviewed and are current. All resident preferences are assessed upon admission, minimally quarterly and as indicated with a change in request of services from family or resident. All staff are trained on timely response of call lights and meeting resident requests upon hire and minimally annually with annual training. We will do an in-service to review the importance of resident preferences and Dignity policy during the week of October 3, 2016. This topic will be discussed at resident council upcoming in October as to resident preference and timeliness of services. Household residents will be interviewed by LSW to learn preference on what time the residents would like to get up and go to sleep each day. A Committee has been formed to discuss on going staffing patterns in the morning/evening and how we can best meet our residents preferences. Reoccurrence will be prevented by: Weekly audits will be done on 10% of the residents to ensure resident s preferences are being met when it comes to preferred wake times and the times they are going to bed. Residents preferred wake times will be added to NAR team sheets. Audits of timely response rates will also be conducted to ensure ongoing needs are being met timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/31/2016

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) COMPLETE DATE
21805	Continued From page 28 room and helped her get dressed for the day. At 9:28 a.m. R80 was assisted out of her room to the dining room and seated at a table by herself, with only two other residents seated in the dining room at a different table. R80 was served breakfast alone in the dining room. When interviewed on 8/31/16, at 9:34 a.m. NA-A stated R80 had complained about not being helped timely in the morning before to her, and residents sometimes have to wait for longer periods if they are short staffed because they are typically, "Really behind," then. During interview on 8/31/16, at 10:03 a.m. LPN-B stated staff, "Try to get them [residents] as we can," and sometimes R80, "Has to wait a little bit" for her cares in the morning. When interviewed on 8/31/16, at 12:20 p.m. LPN clinical coordinator (LPN)-C stated residents should not have to wait for extended periods to be helped with cares adding, "We don't ever want anyone to wait a long period of time," because, "This is their home and they need to feel trust in us." A facility Dignity policy dated 12/2014, identified resident should be cared for, "In a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could inservice staff about ensuring cares are initiated and complete timely for each resident, then complete audits of care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21805	The Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits c. The 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
	00271	A. BUILDING: ___ B. WING ___	08/31/2016

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) COMPLETE DATE
21805	Continued From page 29 (21) days.	21805		

Electronically submitted
September 21, 2016

Ms. Janae Beaudot, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5210025

Dear Ms. Beaudot:

The above facility was surveyed on August 29, 2016 through August 31, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

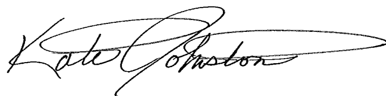
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File