

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.

Lake Minnetonka Shores May 18, 2017 Page 2

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,

Hally Kranz

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

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245210	B. WING		30	8/31/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MIN	NETONKA SHORES			527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 156 SS=D	was completed by su Department of Health Shores was found to the regulations at 42 requirements for Long The facility's plan of c as your allegation of c Department's accepta enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verificatio Upon receipt of an ac on-site revisit of your validate that substant regulations has been your verification. 483.10(b)(5) - (10), 44 RIGHTS, RULES, SE The facility must infor and in writing in a lan understands of his or regulations governing responsibilities during facility must also prov notice (if any) of the S §1919(e)(6) of the Ac made prior to or upon resident's stay. Rece any amendments to it writing. The facility must infor entitled to Medicaid b	ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will n of compliance. ceptable electronic POC, an facility may be conducted to ial compliance with the attained in accordance with B3.10(b)(1) NOTICE OF RVICES, CHARGES m the resident both orally guage that the resident her rights and all rules and resident conduct and the stay in the facility. The ride the resident with the State developed under t. Such notification must be admission and during the upt of such information, and t, must be acknowledged in m each resident who is enefits, in writing, at the time	F 156			9/30/16
		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		(X6) DATE
Electroni	cally 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.

					FORM	: 05/19/2017 APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
	245210	B. WING		_	08/3	31/2016
ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
NETONKA SHORES				94		
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resident becomes elig	pible for Medicaid of the					
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which the resident ma	ay not be charged; those					
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the amount of charge	s for those services; and					
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A description of the re	equirements and procedures					
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non-exempt resource	s at the time of					
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cannot be considered	available for payment					
A posting of names, a	ddresses, and telephone					
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	S FOR MEDICARE & DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER INETONKA SHORES SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR D Continued From page of admission to the nur resident becomes elig items and services the facility services under which the resident ma other items and service and for which the resi the amount of charge inform each resident of the items and service (i)(A) and (B) of this s The facility must infor at the time of admissi the resident's stay, of facility and of charges including any charges under Medicare or by The facility must furni legal rights which incl A description of the m funds, under paragrap A description of the re for establishing eligibil the right to request ar 1924(c) which determ non-exempt resource institutionalization and spouse an equitable s cannot be considered toward the cost of the medical care in his or down to Medicaid eligi A posting of names, a	CORRECTION IDENTIFICATION NUMBER: 245210 ROVIDER OR SUPPLIER NETONKA SHORES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE A. BUILDING 245210 B. WING ROVIDER OR SUPPLIER NETONKA SHORES ID RETONKA SHORES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 1 of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that the facility offers 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 paym	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 245210 STREET ADDRESS, CITY, ST 4527 SHORELINE DRIVE SPRING PARK, MN 553 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WITS THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PROVIDERS (EACH DEFICIENCY WITS THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS CONTINUE AND CONSTRUCTION TAG PROVIDERS (EACH ODREC CROSS-REFERENC TAG Continued From page 1 of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the 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) (1)(A) and (B) of this section. F 156 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services and albe in the facility must furnish a written description of legal rights which includes: 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	MENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAD SERVICES FOR DEFICIENCIES FOR MEDICARE & MEDICAD SERVICES FOR MEDICARE & MEDICARE	MENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICALD SERVICES OMB NC FORMEDICARE & MEDICALD SERVICES OMB NC FORMEDICARE & MEDICALD SERVICES OMB NC FORMEDICARE & MEDICALD SERVICES OMB NC POWDER OR SUMPLER NETONKA SHORES SIMMARY STATEMENT OF DEFICIENCIES ISMMARY STATEMENT OF DEFICIENCIES SIMMARY STATEMENT OF DEFICIENCIES CONSERVICES SCITY, STATE, JIP CODE 4927 SHORELINE DRVE SPRING PARK, MN ESS34 SEQUETORY OR LSC DENTIFYING INFORMATION) 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 shot the facility offers and for which the resident may be charged, those other items and services shot the facility offers and for which the resident may be charged, those other items and services shot the facility offers and for which the resident may be charged, those other items and services shot the facility offers and for which the resident may be charged, those other items and services shot the facility offers and for which the resident may be charged, and the amount of charges for hose services, and inform each resident charges are made to the facility and of the section. The facility must inform each resident before, or at the time of charges for services not covered under Medicare or by the facility's per diem rate. The facility must functiones A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the manner of resources which anome beconsidered 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.

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 APPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245210	B. WING			08/	31/2016
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MIN	NETONKA SHORES				527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 156	agency, the State lice ombudsman program advocacy network, an unit; and a statement complaint with the Sta agency concerning re misappropriation of re facility, and non-comp directives requiremen The facility must infor name, specialty, and physician responsible The facility must prom written information, an applicants for admissi information about how Medicare and Medica receive refunds for pr such benefits. This REQUIREMENT by: Based on interview a facility failed to provid Medicare Non-Covera (R93) reviewed for lia Findings include:	tate survey and certification nsure office, the State , the protection and d the Medicaid fraud control that the resident may file a ate survey and certification sident abuse, neglect, and sident property in the bliance with the advance ts. m each resident of the way of contacting the for his or her care. ninently display in the facility nd provide to residents and on oral and written y to apply for and use id benefits, and how to evious payments covered by is not met as evidenced nd document review, the e the required Notice of age for 1 of 3 residents bility notices.	F	156	Resident 93 was discharged prior to adequate notice given related to famil and resident's wishes to discharge ea than anticipated end date of therapy. Corrective Action as it applies to other residents: The policy and procedure f	rlier	
	would be completing to assisted living on 7	lated 7/13/16, identified R93 herapy and discharge back /15/16. R93 had, "No ons for continued therapy."			Medicare Denials was reviewed and is current. To prevent reoccurrence for other residents the criteria for denial for	3	

Event ID: KN7Z11

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 156 Continued From page 3 F 156 R93's medical record was reviewed. There was Medicare benefits is reviewed daily at IDT no evidence R93 had been provided a Notice of meetings. In-service for this group will be Medicare Non-Coverage (CMS-10123) as held the week of 9/26/2016. Specific required when their Medicare coverage was training and tool kits were created for staff ended. responsible for providing notices. During interview on 8/31/16, at 3:55 p.m. licensed social worker (LSW)-A stated R93 admitted to the Reoccurrence will be prevented by: Audits nursing home for therapy services under will be done weekly by the Resident Medicare Part A coverage. R93 completed his Services Director (LSW) or designee. The audits will be reviewed monthly to check therapy services and was originally planned to discharge on Saturday, 7/16/16, however the for criteria of discharge to make sure assisted living would not accept him on the notices are given timely. weekend. LSW-A stated a decision was made with R93's family to move up his discharge to Correction will be monitored by: Friday, 7/15/16, instead. LSW-A stated R93 was a. The audits will be given to the not provided a Notice of Medicare Non-Coverage Administrator for review. (CMS-10123) because R93, "Chose to go on his b. Administrator will report audits to the QA Team. QA will determine frequency of own wishes prior to the last day." audits c. The Administrator will be responsible for compliance. 483.10(b)(11) NOTIFY OF CHANGES F 157 F 157 10/7/16 (INJURY/DECLINE/ROOM, ETC) SS=D 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

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PRINTED: 05/19/2017 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 157 Continued From page 4 F 157 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 Resident # 148 expired on 5/23/2016 facility failed to inform the resident's physician of Corrective Action as it applies to other pertinent information about the resident's status after the resident fell for 1 of 2 residents (R148) residents: The policy and procedures for reviewed for falls. assessment and provider notification was reviewed and is current. All residents are Findings include: assessed upon admission, minimally quarterly and as needed with change of R148's Admission Record sheet (undated) condition. All residents with change of identified she was admitted to the facility on condition are reviewed with IDT daily and 5/18/16 with diagnoses of end stage renal physicians updated timely as per clinical disease, hypo tension, difficulty walking and a indications and per policy. The facility history of falls. The 5/23/16 admission Minimum EMR also alerts nurses to documentation Data Set identified R148 was on an anticoagulant and report of NARs to potential change in medication (blood thinner), and had received the status each shift. An In-service for medication in the last 6 days. nursing staff will be presented during the week of 10/3/2016 related to recognition Comprehensive Data Collection form dated and assessment of status change and

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 157 Continued From page 5 F 157 5/18/16, identified R148 was oriented to person, timely notification of physician/ provider place and time, with level of consciousness as team including information to be reported. alert. Neurological status noted weakness and a The information presented will review the history of and risk for falls. policy on reporting Change of Condition and Policy on Falls. At this in-service staff R148's Individual Resident Care Plan dated will review eInteract tools, and the 5/18/16, identified R148 was independent with reporting of a Significant Change progress ambulation with use of a walker, and required note. This will ensure ongoing and assist of one for transfers until seen by therapy. consistent monitoring of any change in It also noted R148 was alert and oriented. The condition is completed with medical care plan failed to address the risk for falls. intervention. The Physical Therapy (PT) Plan of Care dated Reoccurrence will be prevented by: 5/18/16, identified muscle weakness and difficulty Audits for significant change will be a. in walking as the treatment diagnosis, with a start completed in daily IDT meeting. All falls of care as 5/18/16. It also noted hospitalization will be reviewed for significant change. for falls and weakness, with three falls in the past Policy will be followed for proper month. R148 was noted to have complaints of notification of provider, Administrator, and weakness, fatigue and impaired balance family. 24 hour report will be reviewed daily impacting ability to ambulate, transfer and b. perform activities of daily living (ADLs) safely and by Clinical Coordinators to check for independently. R148 noted significant fatigue and change in condition. The nurse in charge left knee feeling like it would buckle with gait. of the building will be reviewing on the weekends. The Correction will be monitored by: The facility Therapy to Nursing Functional a. The audits will be given to the Clinical Maintenance Program form dated 5/18/16 Administrator for review. identified R146 was" Independent Toilet, Bed to b. Administrator will report audits to the Chair/Chair to Bed, Sit to Stand." The form also QA Team. QA will determine frequency of identified under Walking, "Independent walking in audits room, A1 [assist of 1] longer distances [100+ feet] c. The Clinical Administrator will be to all destinations." This form was filled out by responsible for ongoing compliance. 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

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/19/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	SURVEY
		245210	B. WING			08/	31/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MIN	INETONKA SHORES				4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From page voicemail at 6:35 p.m A Resident Occurrent 9:00 p.m. identified R floor, noting a fall with and laceration to the I report noted medical including "Pressure to compress to hematon was notified by fax on fall. R148 identified s head hurt, and was he hand. BP noted after Review of the facility monitoring tool used to neurological symptom from 9:00 pm thru 5/2 no changes in neurolo 9:00 p.m. thru 5/23/16 identified on 5/23/16 R148's right and left p but identified there we neuro check even tho slow to respond on th at 9:00 a.m. and 1:00 fell hitting her head re laceration to the back was another entry on sheet after the 1:00 p no date identified (bla identified but just "PM	e 6 . of the fall. the Report dated 5/22/16, at 148 was observed on the the injury, including hematoma back/top of head. The attention was required, to stop bleeding" and "Cold na". The medical provider to 5/23/16 at 1:10 a.m. of the the hit her head, and her bolding her head with one the fall 79/49.		15	DEFICIENCY)		
	physician faxed on 5/ written on the form. T	ransmittal Form sent to the 23/16 which was hand he form identified "6:00 p.m. ining room 'my knees gave					

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SINTENENT OF DEFICIENCIES AND RUNC TO CONSUMPLIE NORMAL STRUCTURE AND RUNC TO CONSUMPLIE 24210 DAILTIPIE CONSTRUCTION A BULLIONS A BULL			D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/19/2017 1 APPROVED 0. 0938-0391
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS LAKE MINNETONKA SHORES STREET ADDRESS, CITY, STATE, 2P CODE 457 SHORELINE DRIVE SPRING PARK, NM 53344 Main Trace Issummary Statement of Deficiencies (Exclusification of Deficiencies) Percent Trace Main Trace Issummary Statement of Deficiencies (Exclusification of Numeric Actions Statement (Exclusification of Numeric Actions Statement Deficience) Percent Providers Actions (State) Date (Exclusification of Deficiencies) F 157 Continued From page 7 out: NARE [nursing assistant registered] caught her and lowered her to a sitting position on floor. ¹ It also identified 79:00 pm. Resident "hought she could do it herself" and ambutated to the bathroom where she fell, hitting the reda. There is a bump on head. VS (Wala signs) and neuro's [neurological checks] are being monitored. Blood pressure after fall was 79:49. It was then 106/74 ther 135:87 There was no further data on the from the physician on 512:3716, identified a change in status for R146 and R146 needed assistance of one for foliciton; bed to charic/chain to bed transfers and at to stand. A change was made to wasking with assistance of one at all times. The form was filled out by physical therapy assistani.A. R148's Care Conference Summary dated 5/23/16, identified R148 Thad 2 falls on Sunday, did hit head'. It also noted "Had increase in weakenss over the weekend and increase as hakiness." The summary noted "Resident was in difficeenced with all mobility, abubation, and self-cares walker but has had a decline over the weekend as is to row SDA (state) by assistify with FWW (four wheeled walker], Balance score puts resident in moderate risk for falls. Resident is SDA (state) by assistify for falls. Resident is SDA (state) by Sizel if of the sing problements".	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY
457 BIORELINE DRIVE SPRING PARK, NN 55334 CALL SUMMARY STATEMENT OF DEFICIENCIES (12.47) DEFICIENCY MUST BE PRECEDED BY FULL (12.47) DEFICIENCY (12.47) DEFICIENCY MUST BE PRECEDED BY FULL (12.47) DEFICIENCY (13.47) DEFICIENCY MUST BE PRECEDED BY FULL (13.47) DEFICIENCY (14.47) DEFICIENCY MUST BE PRECEDED BY FULL (14.47) DEFICIENCY (14.47) DEFICIENCY (14.47) DEFICIENCY MUST BE PRECEDED BY FULL (14.47) DEFICIENCY (14.47) DEFICIENCY (14.47) DEFICIENCY MUST BE PRECED BY BOINT ON ON ON ON (14.47) DEFICIENCY MUST BE PRECED BY BOINT ON ON ON (14.47) DEFICIENCY MUST BE PRECED BY BOINT ON ON ON (15.47) DEFICIENCY MUST BE PRECED BY BOINT ON ON ON (14.47) DEFICIENCY MUST BE PRECED BY BOINT ON ON ON (14.47) DEFICIENCY MUST BE PRECED BY BOINT ON (14.47) DEFICIENCY BY BOINT ON ON (14.47) DEFICIENCY BY BOINT ON ON (14.47) DEFICIENCY BY BOINT ON (14.47) DEFICIENCY BY BOINT ON (14.47) DEFICIENCY			245210	B. WING			08/3	31/2016	
LAKE MININETONIKA SHORES SPRING PARK, MN 55384 (%4)10 PREFIX NG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEASED BY HUL REQUALIONT ONLISC DENTIFYING NETOMATION) ID PREFIX NG PROVIDENTS FLANC OCONFECTION (EACH DEFICIENCY MUST BE RECEASED BY HUL REQUALIONT ONLISC DENTIFYING NETOMATION) ID PREFIX NG PROVIDENTS FLANC OCONFECTION (EACH DEFICIENCY) COMPTTION (EACH DEFICIENCY) F 157 Continued From page 7 out: NAR [nursing assistant registered] caught her and lowered her to a stilling position on floor." It also identified "300 pm. Resident thought she could do it thereself" and ambulated to the bathroom where she fell, hitting here head. There is a bump on head. VS [vital signs] and neuro's [reurological checks] are being monitored. Blood pressure after fall was 79(49, It was then 106/74 then 153(87)" There was no further data on the form was marked" noted" and signed by the physician on 5/23/16, identified a change in status for R146 and R146 needed assistance of one for toilein, pate to chair/chein to bed transfers and sit to stand. A change was made to wasking with assistance of one at all times. The form was filled out by physical therapy assistant-A. R148's Care Conference Summary dated S123/16, identified R143 "Had 2 fails on Sunday, did hit head". It also noted "Had increase in weekness over the weekned and increase in weekness over the weekned and increase shakiness." The summary noted "Resident was in di [independent] with all mobility, abuublation, and self-cares waiker but has had a decline over the weekned as it now SBA [stand by assist] for dressing thou resident in moderate risk for fails. Resident is SBA [stand by assist] for dressing thou resident in moderate risk for fails. Resident is SBA [stand by assist] for dressing thou resident in moderate risk for fails. Resident is SBA [stand by 24/16	NAME OF PF	ROVIDER OR SUPPLIER				, , ,			
PRETRY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR USC (DENTY MUST BE PRECEDED BY FULL REGULTORY OR USC (DENTY MUST BE PRECEDED BY FULL NACE PRETRY TAG C.C.ACH CORRECTED ACTION BROUND BE DEFICIENCY CONVINTION BROUND BE DEFICIENCY F 157 Continued From page 7 out. NAR [fursing assistant registered] caught the rand lowered her to a sitting position on floor." It also identified "9:00 pm. Resident 'thought she could do it herseff' and ambulated to the bathroom where she fell, hitting her head. There is a bump on head. VS [vital signs] and neuro's [neurological check] are being monitored. Blood pressure after fall was 79449. It was then 106/74 then 135/87" There was no further data on the form to the physician offlowing the ellipsis. This form was marked 'noted' and signed by the physician of 52/3/16, and faxeb back to the facility on 5/23/16, identified a change in status for RH46 and RH46 needed assistance of one for toileting, bed to chair/chair to bed transfers and sit to stand. A change was made to waking with assistance of one at all times. The form was filed out by physical therapy assistant-A. R148's Care Conference Summary dated 5/23/16, identified RH48 TH402 falls on Sunday, did hit head". It also noted "Had increase in weakness over the weekend and increase shakiness." The summary noted Resident was ind [independent] with all mobility, ambulation, and self-cares walker but has had a de dice over the weekend as in ow SBA [stand by assist] with FVW [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:	LAKE MIN	NETONKA SHORES							
out. NAR [unusing assistant registered] caught her and lowered her to a sitting position on floor." It also identified '9:00 pm. Resident 'hought 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 7949. 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, 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 thad 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."	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE		COMPLETION
- 5/23/16 at 10:03 a.m. Fax received from MD,	F 157	out'. NAR [nursing as her and lowered her to It also identified "9:00 could do it herself" an bathroom where she f is a bump on head. V [neurological checks] pressure after fall was then 135/87" There form to the physician form was marked "not physician on 5/23/16, facility on 5/23/16, facility on 5/23/16, facility on 5/23/16, at A Therapy to Nursing Program dated 5/23/1 status for R146 and R one for toileting, bed to transfers and sit to sta walking with assistant form was filled out by assistant-A. R148's Care Conferent 5/23/16, identified R14 did hit head". It also n weakness over the we shakiness." The sum ind [independent] with and self-cares walker the weekend as is not FWW [four wheeled we resident in moderate of SBA [stand by assist] Review of R148 progra through 5/24/16, identified R	ssistant registered] caught o a sitting position on floor." pm. Resident 'thought she d ambulated to the fell, hitting her head. There S [vital signs] and neuro's are being monitored. Blood s 79/49. It was then 106/74 was no further data on the following the ellipsis. This ted" and signed by the and faxed back to the 8:29 a.m. Functional Maintenance 6, identified a change in 8:46 needed assistance of to chair/chair to bed and. A change was made to ce of one at all times. The physical therapy the Summary dated 48 "Had 2 falls on Sunday, noted "Had increase in eekend and increased mary noted "Resident was a all mobility, ambulation, but has had a decline over w SBA [stand by assist] with valker]. Balance score puts risk for falls. Resident is for dressing/toileting."	F	15				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES				ING _	E CONSTRUCTION		FORM OMB NC (X3) DATE COMP	0: 05/19/2017 MAPPROVED 0. 0938-0391 SURVEY LETED 31/2016
			SPRING PARK, MN 55384					0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	self-cares walker but I weekend and is not S FWW [four wheeled w - 5/23/16 at 12:47 p.m thought she could do bathroom where she f Resident landed on he head on built in dress with call light close at Injury description was Bleeding and bump as - 5/23/16 at 4:16 p.m. back of head dry, no i - 5/23/16 at 6:16 p.m. very weak and shaky shift, had room tray for cont [continue] to mor -5/23/16 at 22:26 p.m roommate called out f She heard a loud crass entered the room and face down, unrespons rolled to her back and	itled care conference Resident was ind mobility, ambulation, and has had a decline over the BA [stand by assist] with valker]." n. by RN-B "Resident it herself and ambulated to fell in the doorway. er back after hitting her er on way down. Put in bed hand. Close monitor." "Hit back/top of head. s result." by LPN-A "Laceration on nfection noted." by LPN-A "Res [resident] today. Stayed in bed all or dinner, appetite poor. Will	F	157		-FICIENCY)		
	Review of the facility I dated 5/23/16, at 9:45 mark on box with obse	Resident Occurrence Report 5 p.m. identified a check erved on floor, "bleeding on cal attention required, no;						

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 9 F 157 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

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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.

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 241 Continued From page 12 F 241 483.15(a) DIGNITY AND RESPECT OF 10/7/16 F 241 F 241 INDIVIDUALITY SS=D 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 Corrective Action: To correct the deficient review, the facility failed to ensure a dignified practice for resident #80. LSW rising routine was consistently provided for 1 of 3 interviewed resident to make sure we residents (R80) reviewed for dignity. have proper understanding of what time the resident would prefer to rise and go to Findings include: bed. Weekly check-ins with Resident Services for this resident will occur to R80's guarterly Minimum Data Set (MDS) dated ensure resident needs are being met. 7/25/16, identified R80 had intact cognition, required extensive assistance with bed mobility, Corrective Action as it applies to other and was totally dependent on staff for transfers. residents: The policy and procedure for call light response and dignity were During interview on 8/29/16, at 4:24 p.m. R80 reviewed and are current. All resident stated she did not feel staff treated her with preferences are assessed upon admission, minimally quarterly and as dignity because it seemed, "Like there's always a lag of time," in getting assistance with cares and indicated with a change in request of dressing. R80 stated the staff often start helping services from family or resident. All staff her then, "Leave the room and not come back," are trained on timely response of call so R80 has to, "Lay there on the bed waiting for lights and meeting resident requests upon someone to help finish dressing me." R80 stated hire and minimally annually with annual this happens, "All the time," and it makes her feel, training. An in-service will be provided to "Rejected and uncared for." review the importance of resident preferences and Dignity policy during the On 8/31/16, at 7:54 a.m. R80 was in bed in her week of October 3, 2016. This topic will room with her call light turned on. Licensed be discussed at resident council practical nurse (LPN)-B entered the room and upcoming in October as to resident turned off R80's call light. LPN-B applied a preference and timeliness of services. cream to R80's legs and asked her, "Are you Household residents will be interviewed by

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 241 Continued From page 13 F 241 ready to get up?" R80 stated she had, "Been LSW to learn preference on what time the waiting to get up," to which LPN-B stated she residents would like to get up and go to would inform the nursing assistant (NA) staff. At sleep each day. A committee has been 7:57 a.m. R80 again turned on her call light formed to discuss ongoing staffing outside the room. LPN-B entered the room and patterns in the morning/evening and how turned off the call light and told R80 the NA staff we can best meet our residents would be coming, "In a minute." LPN-B then preferences. applied a warm washcloth to R80's eyes and left the room. Reoccurrence will be prevented by: Weekly Audits will be done on 10% of the At 8:25 a.m. R80 remained in bed without any residents to ensure resident s assistance being offered to help her get up or preferences are being met when it comes ready for the day as she had requested. R80 to preferred wake times and the times stated she was, "Waiting on my aides [NA]," and they are going to bed. Residents had been waiting for help to get up, "since 7:30 preferred wake times will be added to [a.m.]." R80 stated having to wait this long for NAR team sheets. Audits of timely help had happened before, and it makes her feel, response rates will also be conducted to "Lonelier because I have to eat by myself [in the ensure ongoing needs are being met dining room]." At 8:29 a.m. (thirty five minutes timely. after observation began) NA-A entered R80's The Correction will be monitored by: room and helped her get dressed for the day. At 9:28 a.m. R80 was assisted out of her room to The audits will be given to the а the dining room and seated at a table by herself, Administrator for review. with only two other residents seated in the dining b. Administrator will report audits to the room at a different table. R80 was served QA Team. QA will determine frequency of breakfast alone in the dining room. audits c. The Administrator will be responsible When interviewed on 8/31/16, at 9:34 a.m. NA-A for compliance. 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.

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245210	B. WING		08/31/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE MIN	INETONKA SHORES			4527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 241	Continued From page	e 14	F 24		
	clinical coordinator (L should not have to wa be helped with cares anyone to wait a long	8/31/16, at 12:20 p.m. LPN PN)-C stated residents ait for extended periods to adding, "We don't ever want period of time," because, and they need to feel trust in			
F 282	resident should be ca an environment that and/or enhancement life."	y dated 12/2014, identified ared for, "In a manner and in promotes maintenance of each resident's quality of VICES BY QUALIFIED	F 282	2	10/7/16
SS=D	The services provide must be provided by	d or arranged by the facility			
	by: Based on observation review, the facility fait interventions to promove residents (R80) revien Findings include:	is not met as evidenced in, interview and document led to implement care plan ote skin integrity for 1 of 4 wed for pressure ulcers.		Corrective Action: To correct this for resident 80, upon identification that he were not being floated, it was immedia corrected and staff involved were re-educated on resident plan of care. care plan was reviewed and is current The Team Sheet was updated to match Care Plan interventions.	The
	7/25/16, identified R8 required extensive as	num Data Set (MDS) dated 0 had intact cognition, ssistance with bed mobility, essure ulcer formation.		Corrective Action as it applies to other residents: The policy and procedure f care plan was reviewed and is current residents are assessed on admission	for t. All

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 15 F 282 "Limited physical mobility in bed," and R80 had, and My Best Day/assignment sheet are "Potential for alteration in skin integrity." The care reviewed minimally quarterly and with change in status and updated with anv plan directed staff to, "Keep heels elevated in bed." changes. We will audit the team sheets to make sure the current team sheets match During observation of morning care on 8/31/16. at the care plan for each resident. When 8:29 a.m. R80 was laying in her room in bed. there is a change in care the Clinical Nursing assistant (NA)-A pulled back R80's Coordinators (or designee) will update the bedding exposing R80's legs and feet. R80's team sheets and the care plan. There will heels were not being floated with any devices or be an in-service regarding the process of pillows, instead they were directly on the updating of care plan and team sheets for mattress. R80 stated, "My heel hurts," and the all nursing the week of October 3, 2016. back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 Reoccurrence will be prevented by: was assisted to the bathroom and NA-A stated Weekly Audits will be completed by R80 reddened heel, "Kind of feels soft." Clinical Coordinators. They will chose 10% of the residents each week to make When interviewed on 8/31/16, at 9:34 a.m. NA-A sure care plans match team sheets and stated R80's heels were not being floated when that the services indicated on the plan of she removed her bedding and her right heel was care are being followed. reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when The Correction will be monitored by: she would assist her with morning cares. Further, The audits will be given to the Clinical а NA-A stated R80's heels have been red in the Administrator for review. morning before when they are not floated, "Their Administrator will report audits to the b usually red." QA Team. QA will determine frequency of audits During interview on 8/31/16, at 9:52 a.m. licensed The Clinical Administrator will be C. practical nurse (LPN)-B stated the care plan was responsible for compliance. 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.

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245210	B. WING		08/31/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE MIN	INETONKA SHORES			4527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 282	A facility Care Plan P 4/2016, identified a c "Ensure the resident required to maintain	e 16 Policy and Procedure dated are plan was used to, has the appropriate care or attain the resident's icable function possible."	F 282	2	
F 309 SS=D	483.25 PROVIDE CA HIGHEST WELL BEI		F 309	3	10/7/16
	provide the necessar or maintain the highe mental, and psychos	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment			
	by: Based on interview a facility failed to accur significant change ab the resident fell, for 1 reviewed for acciden Findings include: R148's Admission Re identified she was ad 5/18/16 with diagnos disease, hypo tension history of falls. R148' Set dated 5/23/16, id anticoagulant medicat R148's Comprehension	ecord sheet (undated) mitted to the facility on		Resident #148 expired on 5/23/2016 Corrective Action as it applies to other residents: The policy and procedures assessment and provider notification reviewed and is current. All residents assessed upon admission, minimally quarterly and as needed with change condition. All residents with change of condition are reviewed with IDT daily physicians updated timely as per clinic indications and per policy. The facility EMR also alerts nurses to documenta and report of NARs to potential change status each shift. An in-service for nursing staff will be presented during week of 10/3/2016 related to recogniti and assessment of status change and timely notification of physician/ provide	for was are of of and cal v tion le in the on

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 17 F 309 person, place and time, with level of team including information to be reported. consciousness as alert. Further, the neurological The information presented will review the status noted weakness and a history of and risk policy on reporting Change of Condition for falls. and Policy on Falls. At this in-service staff will review eInteract tools, and the R148's Individual Resident Care Plan dated reporting of a Significant Change progress 5/18/16, identified R148 was independent with note. This will ensure ongoing and ambulation with use of a walker, and required consistent monitoring of any change in assist of one for transfers until seen by therapy. condition is completed with medical It also noted R148 was alert and oriented. The intervention. care plan failed to address the risk for falls. Reoccurrence will be prevented by: The Physical Therapy (PT) Plan of Care dated a. Audits for significant change will be 5/18/16, identified muscle weakness and difficulty completed in daily IDT meeting. All falls in walking as the treatment diagnosis, with a start will be reviewed for significant change. of care as 5/18/16. It also noted hospitalization Policy will be followed for proper for falls and weakness, with three falls in the past notification of provider, Administrator, and month. R148 was noted to have complaints of family. b. 24 hour report will be reviewed daily by weakness, fatigue and impaired balance Clinical Coordinators to check for change impacting ability to ambulate, transfer and perform activities of daily living (ADLs) safely and in condition. The nurse in charge of the independently. R148 noted significant fatigue and building will be reviewing on the left knee feeling like it would buckle with gait. weekends. The Correction will be monitored by: The facility Therapy to Nursing Functional a. The audits will be given to the Clinical Maintenance Program form dated 5/18/16, Administrator for review. identified R148 was "Independent Toilet, Bed to b. Administrator will report audits to the Chair/Chair to Bed, Sit to Stand." The form also QA Team. QA will determine frequency of identified under Walking, "Independent walking in audits room, A1 [assist of 1] longer distances [100+ feet] c. The Clinical Administrator will be to all destinations." This form was completed by responsible for ongoing compliance. 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

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/19/2017 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		245210	B. WING			08/3	31/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
	NETONKA SHORES		4				
				SPRING PARK, MN 55384	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page voicemail at 6:35 p.m	of the fall.	F 309				
	9:00 p.m. identified R floor, noting a fall with and laceration to the R report noted medical a including "pressure to compress to hematom was notified by fax on hours and 10 minutes R148 identified she hi hurt, and was holding noted after the fall wa Review Form dated 5 of the residents positi The picture identified dresser, which was ne television. Review of the facility I monitoring tool used to neurological symptom from 9:00 pm thru 5/2 no changes in neurolo 9:00 p.m. thru 5/23/16, R148's right and left p but identified there we neuro check even tho slow to respond on th at 9:00 a.m. and 1:00 fell hitting her head re laceration. There was Check Flow sheet afte there was no date ide	Neuro Check Flow sheet (a o identify changes in a changes), dated 5/22/16 3/16 at 1:00 p.m. identified ogical status from 5/22/16 at 5 at 5:00 a.m. The sheet at 9:00 a.m. and 1:00 p.m. oupils were slow to respond ere no changes from last ugh R148's pupils were ese two separate occasions p.m., 12 hours after R148 esulting in a hematoma and another entry on the Neuro er the 1:00 p.m. notation but ntified (blank) and no					
	specific time identified	d but just "PM". This entry and pupils were equal and					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/19/2017 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	SURVEY
		245210	B. WING		-	08/3	31/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
LAKE MIN	INETONKA SHORES			4527 SHORELINE DRIVE SPRING PARK, MN 5538	34		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 19	F 309				
	to the the physician w 5/23/16, which was had form identified: "6:00 dining room 'my knee assistant registered] of to a sitting position or "9:00 pm. Resident 'th herself' and ambulate she fell, hitting her he head. VS [vital signs] checks] are being mo after fall was 79/49. If 135/87" There was to the physician follow was marked, "Noted" on 5/23/16, and faxed 5/23/16, at 8:29 a.m. An undated facility Fa was reviewed. The for the occurrence, howe interventions of reside with all transfers, and increased weakness. (international normaliz for measurement of a clotting, was within no date or time identified completed for the long A Therapy to Nursing Program dated 5/23/1 status for R148. R148	Neuro at baseline and INR zed ratio), a laboratory test nticoagulants for blood ormal limits. There was no of when this form was					
	A Therapy to Nursing Program dated 5/23/1 status for R148. R148 for toileting, bed to ch and sit to stand. A cha	Functional Maintenance 6, identified a change in 8 needed assistance of one					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES 245210 STREET ADDRESS, CITY, STATE, ZIP CODE 08/31/2016 (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (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 F 309			ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/19/2017 // APPROVED). 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKE MINNETONKA SHORES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (xs COMPLE DAT F 309 Continued From page 20 completed by physical therapy assistant-A. F 309 F 309 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 F 309	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY
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) Complete DAT F 309 Continued From page 20 completed by physical therapy assistant-A. F 309 F 309 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 F 309			245210	B. WING				08/	31/2016
LAKE MINNETONKA SHORES SPRING PARK, MN 55384 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Completed DAT F 309 Continued From page 20 completed by physical therapy assistant-A. F 309 F 309 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 F 309	NAME OF PI	ROVIDER OR SUPPLIER					TATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DAT F 309 Continued From page 20 completed by physical therapy assistant-A. F 309 F	LAKE MIN	INETONKA SHORES					384		
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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		(X5) COMPLETION DATE
 shakines." 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 through the 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." 	F 309	completed by physical R146's Care Conferent 5/23/16, identified: "[F did hit head." It also it weakness over the we shakiness." The sum ind [independent] with and self-cares walker the weekend as is not FWW [four wheeled we resident in moderate it SBA [stand by assist] Review of R148's pro- through 5/24/16, iden - 5/23/16 at 10:03 a.m "fall noted". - 5/23/16 at 8:23 am of identified "Resident we mobility, ambulation, it has had a decline ove SBA [stand by assist] walker]." - 5/23/16 at 12:47 p.m thought she could do bathroom where she Resident landed on h head on built in dress with call light close at Injury description was Bleeding and bump a - 5/23/16 at 4:16 p.m.	al therapy assistant-A. nce Summary dated R148] had 2 falls on Sunday, noted: "Had increase in eekend and increased mary noted: "Resident was n all mobility, ambulation, "but has had a decline over w SBA [stand by assist] with valker]. Balance score puts risk for falls. Resident is for dressing/toileting." gress notes dated 5/18/16, tified the following: n. Fax received from MD, care conference summary, vas ind [independent] with all and self-cares walker but er the weekend and is not with FWW [four wheeled n. by RN-B "Resident it herself and ambulated to fell in the doorway. er back after hitting her ser on way down. Put in bed hand. Close monitor." a "Hit back/top of head. s result."	F	309		DEFICIENCY)		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION		(X3) DATE	
		245210	B. WING			08/	31/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
LAKE MIN	NETONKA SHORES			527 SHORELINE DRIVE	384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	very weak and shaky shift, had room tray for cont [continue] to mor -5/23/16 at 22:26 p.m roommate called out f She heard a loud crass entered the room and face down, unrespons rolled to her back and [respirations] absent, DNR/DNI." Review of the facility I dated 5/23/16, at 9:45 mark on box observed R [right] cheek." Medi first aid required, no; v identified R148 was u respond verbally and The physician was no p.m. Review of the PT Dail 5/23/16: "PTA [physic nursing of pt [patient] and shakiness. Due t got a w/c [wheelchair] very weak after 2nd fa in speaking." The PT - Therapist Pr Summary dated 5/24/ passed away unexpeat decline over the past	by LPN-A "Res [resident] today. Stayed in bed all or dinner, appetite poor. Will hitor." . by LPN-A "Res [resident] for a nurse from the hallway. sh that woke her up. Writer found res [resident] lying sive. Res [resident] was sternal rub tried. Resp pulse absent, res [resident] Resident Occurrence Report 5 p.m. identified a check d on floor and, "bleeding on cal attention required, no; witness, no. The form nconscious, unable to "res [resident] had expired." tified on 5/23/16 at 11:00 y Treatment Notes on following: al therapy assistant] alerted grey coloring, weakness to pt increased weakness for pt." It also noted "Pt all. Pt shaky even with voice	F 309				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

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Facility ID: 00271

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 24 F 309 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 314 483.25(c) TREATMENT/SVCS TO F 314 10/7/16 PREVENT/HEAL PRESSURE SORES SS=D Based on the comprehensive assessment of a

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Event ID: KN7Z11

Facility ID: 00271

If continuation sheet Page 25 of 28

		D HUMAN SERVICES MEDICAID SERVICES			FORM): 05/19/2017 / APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
245210			B. WING		08/31/2016	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MINNETONKA SHORES				527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314			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 skin risk and pressure ulcer prevention was reviewed and is current. To prev reoccurrence for other residents we we pull a report of all pressure issues in Click Care and audit the Care Plan to make sure the proper instructions are Team Sheets. An in-service will be her reviewing the Skin at Risk Policy to fo floating of heels and points of pressur The Team Sheets will be reviewed to insure all areas of concern are addree All residents are assessed upon admission for skin risk and the care pla and my best day/ team sheet update interventions. All residents are assess minimally quarterly and with change status impacting risk and the care pla and my best day/ team sheet are upon	for on vent Point e on eld ollow re. ssed. d with ssed of n lated	
	R80's most recent Body Audit dated 8/15/16,			to reflect interventions or changes in		

Facility ID: 00271

If continuation sheet Page 26 of 28

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 245210 B. WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 26 F 314 identified R80 had no current pressures and her risk. heels were described as, "Clear." Reoccurrence will be prevented by: During observation of morning care on 8/31/16, at Clinical Coordinator or designee auditing 8:29 a.m. R80 was laying in her room in bed. the care plan, assessment and team Nursing assistant (NA)-A pulled back R80's sheets to ensure all of the information is bedding exposing R80's legs and feet. R80's accurate. Staff will audit 10% of the heels were not being floated with any devices or residents each week to make sure all pillows, instead they were directly on the areas are matching and that the mattress. R80 stated, "My heel hurts," and the interventions are in place. back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 The Correction will be monitored by: was assisted to the bathroom and NA-A stated a. The audits will be given to the Clinical R80 reddened heel, "Kind of feels soft." Administrator for review. b. The Clinical Administrator will report When interviewed on 8/31/16. at 9:34 a.m. NA-A audits to the QA Team. QA will determine stated R80's heels were not being floated when frequency of audits. she removed her bedding and her right heel was c. The Administrator will be responsible reddened. NA-A stated she had noticed times in for compliance. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Facility ID: 00271

If continuation sheet Page 27 of 28

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245210		B. WING			08/31/2016			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	INETONKA SHORES				527 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)			IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	314				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 28 of 28

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISI	Г
IDENTIFICATION NUMBER	A. Building			
245210 _{Y1}	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 DATE		ITEM DATE		ITEM	DATE		
Y4 Y5		Y5	Y4	Y5	Y4		Y5
ID Prefix	F0156	Correction	ID Prefix F0157	Correction	ID Prefix	F0241	Correction
Reg. #	483.10(b)(5) - (10 483.10(b)(1)), Completed	483.10(b)(11) Completed	Reg. #	483.15(a)	Completed
LSC		10/07/2016	LSC	09/30/2016	LSC		10/07/2016
ID Prefix	F0282	Correction	ID Prefix F0309	Correction	ID Prefix	F0314	Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. #	483.25(c)	Completed
LSC		10/07/2016	LSC	10/07/2016	LSC		10/07/2016
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Reg. #		Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
REVIEWED BY STATE AGENCY		date 10/15/2016	SIGNATURE OF SURVEYOR	2209		date 10/27/2016	
REVIEWED BY REVIEWED BY CMS RO (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							ID: KN7Z			
	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY	YAGE	NCY		Fa	acility ID: 00271
1. MEDICARE/MEDICAID PROVIDER N (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 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		(L6) 55384		 TYPE OF ACTION Initial Termination Validation 		2. Recertification 4. CHOW 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 06/03/2010			<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site 8. Full Su	9. Other nplaint				
6. DATE OF SURVEY 10/31. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI			FISCAL YEA	R ENDING I // 30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY X A. In Complian Program Rec Compliance	ace With quirements Based On:		2 3	2. Technic 5. 24 Hour	al Personnel r RN	7. M	cope of Servic edical Direct	or
12.Total Facility Beds 13.Total Certified Beds	131 (L18)131 (L17)	B. Not in Comp	cceptable POC liance with Program and/or Applied Waive	ers:		. 7-Day F i. Life Sat A	-) 8. Pa 9. Bo (L12)	itient Room S eds/Room	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 131	19 SNF	ICF	IID		15. FACIL 1861 (e)	LITY MEE (1) or 186		(1	L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) S (IF APPLICABLE S	(L42)	(L43) ATION DATE):							
17. SURVEYOR SIGNATURE		Date :			18. STATE	E SURVE	Y AGENCY AP	PPROVAL		Date:
Brenda Fisch	er, HFE NE	II	10/31/2016	(L19)	Kate	John	sTon, Pı	rogram Sp	oecialis	<u>t</u> 11/15/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE	OR SIN	IGLE STAT	TE AGENCY		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible	20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 						
2. Facility is not Eligible	(L21)									
22. ORIGINAL DATE OF PARTICIPATION 01/01/1977 (L24)	23. LTC AGREEM BEGINNING (L41)		 LTC AGREEME ENDING DATE (L25) 		<u>VOLUNTA</u> 01-Merger,	<u>ARY</u> , Closure	N ACTION: <u>0(</u> // Reimburseme		INVOLUNTA	et Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV	of Admissions:	(L44)		03-Risk of I 04-Other Ro		y Termination Withdrawal		<u>OTHER</u> 07-Provider S 00-Active	Status Change
	B. Rescind Sus	pension Date:	(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMA	RKS				
	(L28)	00320		(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C 11/01/2016	OF APPROVAL DAT	Έ	Post	ted 11/1	8/2016 Co.			
	(L32)			(L33)	DETERM	MINATI	ON APPRO	VAL		



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.

Lake Minnetonka Shores November 15, 2016 Page 2

Sincerely,

ate Comston Ł

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 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.

Lake Minnetonka Shores November 15, 2016 Page 2

Sincerely,

ato Comston X

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REV	/ISIT
IDENTIFICATION NUMBER	A. Building			
245210 _{Y1}	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).

ITE	vi	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. #	F0156 483.10(b)(5) - (10 483.10(b)(1)), Correction	ID Prefix F01	157 3.10(b)(11)	Correction Completed	ID Prefix Reg. #	F0241 483.15(a)		Correction Completed
LSC		10/07/2016	LSC		09/30/2016	LSC			10/07/2016
ID Prefix	F0282	Correction	ID Prefix F03	309	Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. # 483	3.25	Completed	Reg. #	483.25(c)		Completed
LSC		10/07/2016			10/07/2016	LSC			10/07/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		_	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC						LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC						LSC			
REVIEWE		REVIEWED BY (INITIALS) PK/KJ	date 10/15/201	SIGNATURE OF		32209		date 10/2	7/2016
REVIEWE	D BY	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?						в 🔲 но	

POST-CERTIFICATION REVISIT REPORT

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

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0050	09/06/2016	LSC			LSC _		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC _		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC _		-
REVIEWE			DATE	SIGNATURE OF SU	JRVEYOR	1	DATE	
STATE AG		(INITIALS) TL/KJ	11/15/2016		32	209	10	/11/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/2/2016			ANY UNCORRECTE				s 🗌 no	

POST-CERTIFICATION REVISIT REPORT

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

ITEI	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correcti	on ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Comple	ted Reg. #	Completed
LSC	K0050	09/06/2016	LSC		LSC	
ID Prefix		Correction	ID Prefix	Correcti	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	ted Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correcti	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	ted Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correcti	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	ted Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correcti	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	ted Reg. #	Completed
LSC			LSC		LSC	
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	date 11/15/2016	SIGNATURE OF SURVEYOR	32209	date 10/11/2016
REVIEWE CMS RO	D BY	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?				

STATE FORM: REVISIT REPORT

			DATE OF REVISIT	
	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).

ITE	M	DATE	ITEM		DATE	ITEM		DATE	
Y4		Y5	Y4		Y5	Y4		Y5	
ID Prefix	20265	Correction	ID Prefix 205	65	Correction	ID Prefix	20830	Correction	
Reg. #	MN Rule 4658.00	85 Completed	MN Reg. # Subp	Rule 4658.0405 p. 3	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed	
LSC		10/07/2016			10/07/2016	LSC		10/07/2016	
ID Prefix	20900	Correction	ID Prefix 218	00	Correction	ID Prefix	21805	Correction	
Reg. #	MN Rule 4658.05 Subp. 3	25 Completed	Reg. # MN Subo	St. Statute144.651 d. 4	Completed	Reg. #	MN St. Statute 144.6 Subd. 5	Completed	
LSC		10/07/2016	LSC		09/30/2016	LSC		10/07/2016	
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC		_	LSC			
ID Prefix		Correction	ID Prefix			ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC		_	LSC			
REVIEWE		REVIEWED BY (INITIALS) PK/KJ	date 11/15/201	SIGNATURE OF S		2209	1	date 10/27/2016	
REVIEWE		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,

Late Compton

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

					AND TRANSMITTAL ID: KN72 XTE SURVEY AGENCY Facility II			D: KN7Z Facility ID: 00271
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245210 2.STATE VENDOR OR MEDICAID NO. (L2) 172043100 5. EFFECTIVE DATE CHANGE OF OWN		 NAME AND ADDRESS OF FACILITY (L3) LAKE MINNETONKA SHORES (L4) 4527 SHORELINE DRIVE (L5) SPRING PARK, MN PROVIDER/SUPPLIER CATEGORY 		(L6) 55384		 TYPE OF ACTION: Initial Termination Validation On-Site Visit 	<u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
(L9) 06/03/2010		01 Hospital	05 HHA	09 ESRD	13 PTIP 2	2 CLIA	8. Full Survey After Co	mplaint
6. DATE OF SURVEY 08/31/	2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING	DATE: (L35)
 ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE		09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY I	S CERTIFIED AS:			I		
From (a):		A. In Complian	ce With		And/Or Approved W	aivers Of The	Following Requirements:	
To (b) :		Program Rec Compliance	Based On:		2. Technical 3. 24 Hour F	RN	6. Scope of Servi 7. Medical Direc	tor
12. Total Facility Beds	131 (L18)	I. A	cceptable POC		4. 7-Day RN		8. Patient Room S	size
13. Total Certified Beds	131 (L17)	-	oliance with Program nd/or Applied Waive	ers.	5. Life Safet * Code: B *	y Code	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN			na or rippiloa marte		15. FACILITY MEET	s	(212)	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861		(L15)	
131	17 511	101				0)(1).		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL.	ATION DATE):					
17. SURVEYOR SIGNATURE	17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date:						Date:	
Austin Fry, H	FE NE II	1	0/03/2016	(L19)	Kate Johns	<u> Ton, Pro</u>	ogram Specialis	t 10/27/2016 (L20)
	PART II - TO	BE COMPLETEI) BY HCFA RE	GIONAL	OFFICE OR SINC	GLE STATI	E AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part	icipate		PLIANCE WITH CI TS ACT:	VIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 24	4. LTC AGREEME	NT	26. TERMINATION	ACTION:	(L30)
OF PARTICIPATION 01/01/1977	BEGINNING	DATE	ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Closure	00	05-Fail to M	<u>'ARY</u> eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ I		t 06-Fail to M	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary		OTHER	
	A. Suspension	of Admissions:			04-Other Reason for W	ithdrawal		Status Change
(L27)	B. Rescind Sus	mansion Data	(L44)				00-Active	
	D. Reseniu Sus	pension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/CA	ARRIER NO.		30. REMARKS			
00320								
		00320						
	(L28)	00320		(L31)	Posted 11/01/2	2016 Co.		
31. RO RECEIPT OF CMS-1539		00320 2. DETERMINATION C	F APPROVAL DAT		Posted 11/01/	2016 Co.		



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:

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

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<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.

Lake Minnetonka Shores September 21, 2016 Page 4

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

Lake Minnetonka Shores September 21, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Lake Minnetonka Shores September 21, 2016 Page 6

> Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Inston

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		245210	B. WING _			08/	31/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
LAKE MI	NNETONKA SHORES	5		4527 SHORELINE DRIVE SPRING PARK, MN 553	384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPP FICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00			
	was completed by s Department of Hea Shores was found t the regulations at 4 requirements for Lo	1/16, a recertification survey surveyors from the Minnesota Ith (MDH). Lake Minnetonka to not be in compliance with 2 CFR Part 483, subpart B, ong Term Care Facilities. f correction (POC) will serve	10/03/1 ДРЛ	6			
F 156 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has been your verification. 483.10(b)(5) - (10),	of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will	F 1	56			9/30/16
	and in writing in a la understands of his regulations governin responsibilities duri facility must also prinotice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re- any amendments to writing.	form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in					
		benefits, in writing, at the time					
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE			(X6) DATE
Electron	ically 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.

PRINTED: 10/03/2016

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/03/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		245210	B. WING			08/31/2016		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE M	INNETONKA SHORES	;			4527 SHORELINE DRIVE SPRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 156	of admission to the resident becomes e items and services facility services und which the resident r other items and ser and for which the re- the amount of charg inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admis the resident's stay, facility and of charg including any charg under Medicare or I The facility must fun legal rights which in A description of the for establishing elig the right to request 1924(c) which dete non-exempt resour- institutionalization a spouse an equitable cannot be consider toward the cost of t medical care in his down to Medicaid e	nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and at when changes are made to ces specified in paragraphs (5) a section. Form each resident before, or asion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate. Thish a written description of acludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending	F 1	156				

If continuation sheet Page 2 of 28

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING _		08/;	31/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE SPRING PARK, MN 55384	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	groups such as the agency, the State li ombudsman progra advocacy network, unit; and a stateme complaint with the S agency concerning misappropriation of facility, and non-cor directives requirem The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi	State survey and certification censure office, the State im, the protection and and the Medicaid fraud control nt that the resident may file a State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance	F 15	56		
	by: Based on interview facility failed to prov	NT is not met as evidenced and document review, the vide the required Notice of erage for 1 of 3 residents liability notices.		Resident 93 was discharged prior adequate notice given related to fa and resident's wishes to discharge than anticipated end date of therap	amily earlier	
	would be completin to assisted living or	e dated 7/13/16, identified R93 g therapy and discharge back 17/15/16. R93 had, "No ations for continued therapy."		Corrective Action as it applies to o residents: The policy and procedu Medicare Denials was reviewed an current. To prevent reoccurrence for other residents the criteria for denial for	ire for	

Facility ID: 00271

If continuation sheet Page 3 of 28

PRINTED: 10/03/2016 FORM APPROVED

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	COM	PLETED
		245210	B. WING		08/3	31/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE		
LAKE MI	INNETONKA SHORES	8				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 156	R93's medical reco no evidence R93 h Medicare Non-Cov required when their ended. During interview or social worker (LSW nursing home for th Medicare Part A co therapy services ar discharge on Satur assisted living wou weekend. LSW-A with R93's family to Friday, 7/15/16, ins not provided a Noti	ord was reviewed. There was ad been provided a Notice of erage (CMS-10123) as r Medicare coverage was n 8/31/16, at 3:55 p.m. licensed /)-A stated R93 admitted to the nerapy services under verage. R93 completed his nd was originally planned to rday, 7/16/16, however the ld not accept him on the stated a decision was made o move up his discharge to stead. LSW-A stated R93 was ce of Medicare Non-Coverage use R93, "Chose to go on his	F 156	 Medicare benefits is reviewed daily meetings. In-service for this group held the week of 9/26/2016. Speci training and tool kits were created to responsible for providing notices. Reoccurrence will be prevented by will be done weekly by the Resident Services Director (LSW) or designed audits will be reviewed monthly to a for criteria of discharge to make su 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 QA Team. QA will determine frequaudits 	will be fic for staff : Audits it ee. The check ire to the ency of	
F 157 SS=D	(INJURY/DECLINE A facility must imm consult with the res known, notify the re or an interested far accident involving t injury and has the p intervention; a sign physical, mental, o deterioration in hea status in either life clinical complicatio significantly (i.e., a	TFY OF CHANGES E/ROOM, ETC) ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse	F 157	c. The Administrator will be respo for compliance.	nsible	10/7/16

Facility ID: 00271

If continuation sheet Page 4 of 28

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 10/03/2016 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245210	B. WING	i		/31/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE MI	NNETONKA SHORES	;			527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	treatment); or a dec the resident from the §483.12(a). The facility must als and, if known, the re or interested family change in room or r specified in §483.1 resident rights under regulations as spect this section. The facility must react the address and ph legal representative This REQUIREMEN by: Based on interview facility failed to infor pertinent informatio after the resident fer reviewed for falls. Findings include: R148's Admission Fi identified she was a 5/18/16 with diagno disease, hypo tensi history of falls. The Data Set identified	o commence a new form of cision to transfer or discharge re facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced r and document review, the rm the resident's physician of n about the resident's status ill for 1 of 2 residents (R148) Record sheet (undated) admitted to the facility on uses of end stage renal on, difficulty walking and a 5/23/16 admission Minimum R148 was on an anticoagulant hinner), and had received the	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	
	Comprehensive Da	ta Collection form dated			and assessment of status change and	

Facility ID: 00271

				ייסו			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245210	B. WING			08/3	31/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	6		45 S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	5/18/16, identified I place and time, wit alert. Neurological history of and risk f R148's Individual F 5/18/16, identified I ambulation with us assist of one for tra It also noted R148 care plan failed to a The Physical Thera 5/18/16, identified I in walking as the tr of care as 5/18/16. for falls and weakn month. R148 was weakness, fatigue impacting ability to perform activities o independently. R14 left knee feeling like The facility Therapy Maintenance Progr identified R146 was Chair/Chair to Bed, identified under Wa room, A1 [assist of to all destinations." Physical Therapy-A A Resident Occurre 6:00 p.m. identified without injury. R144	R148 was oriented to person, h level of consciousness as status noted weakness and a for falls. Resident Care Plan dated R148 was independent with e of a walker, and required ansfers until seen by therapy. was alert and oriented. The address the risk for falls. apy (PT) Plan of Care dated muscle weakness and difficulty eatment diagnosis, with a start It also noted hospitalization ess, with three falls in the past noted to have complaints of and impaired balance ambulate, transfer and of daily living (ADLs) safely and 48 noted significant fatigue and e it would buckle with gait. y to Nursing Functional ram form dated 5/18/16 s" Independent Toilet, Bed to , Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] ' This form was filled out by	F 1	57	timely notification of physician/ pro- team including information to be re The information presented will revi- policy on reporting Change of Con- and Policy on Falls. At this in-serv- will review elnteract tools, and the reporting of a Significant Change p note. This will ensure ongoing and consistent monitoring of any change condition is completed with medica- intervention. Reoccurrence will be prevented by a. Audits for significant change w completed in daily IDT meeting. All will be reviewed for significant char Policy will be followed for proper notification of provider, Administrat family. b. 24 hour report will be reviewed by Clinical Coordinators to check for change in condition. The nurse in co of the building will be reviewing on weekends. The Correction will be given to the C Administrator for review. b. Administrator for review. b. Administrator will report audits to QA Team. QA will determine frequ audits c. The Clinical Administrator will be responsible for ongoing compliance	ported. ew the dition ice staff orogress l je in al : ill be falls nge. d daily or charge the y: linical o the ency of	

If continuation sheet Page 6 of 28

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING			08/;	31/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	INNETONKA SHORES	3		-	527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	 9:00 p.m. identified floor, noting a fall w and laceration to th report noted medica including "Pressure compress to hemat was notified by fax fall. R148 identified head hurt, and was hand. BP noted afte Review of the facilit monitoring tool use neurological sympto from 9:00 pm thru 5 no changes in neur 9:00 p.m. thru 5/23/1 R148's right and lef but identified there neuro check even t slow to respond on at 9:00 a.m. and 1:0 fell hitting her head laceration to the ba was another entry of sheet after the 1:00 no date identified (k identified but just "F changes, and pupils light. A Facility Facsimile physician faxed on written on the form. 	.m. of the fall. ence Report dated 5/22/16, at I R148 was observed on the vith injury, including hematoma he back/top of head. The al attention was required, to stop bleeding" and "Cold toma". The medical provider on 5/23/16 at 1:10 a.m. of the d she hit her head, and her a holding her head with one	F 1	57			

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		AND HUMAN SERVICES			FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245210	B. WING		08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	;		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	out'. NAR [nursing her and lowered he It also identified "9: could do it herself" bathroom where sh is a bump on head. [neurological check pressure after fall w then 135/87" The form to the physicia form was marked "1 physician on 5/23/1 facility on 5/23/16, a A Therapy to Nursir Program dated 5/23 status for R146 and one for toileting, be transfers and sit to walking with assista form was filled out I assistant-A. R148's Care Confe 5/23/16, identified F did hit head". It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is n FWW [four wheeled resident in moderat SBA [stand by assis Review of R148 pro	assistant registered] caught assistant registered] caught of to a sitting position on floor." 00 pm. Resident 'thought she and ambulated to the he fell, hitting her head. There VS [vital signs] and neuro's iss] are being monitored. Blood vas 79/49. It was then 106/74 ere was no further data on the an following the ellipsis. This noted" and signed by the 6, and faxed back to the at 8:29 a.m. ng Functional Maintenance 3/16, identified a change in d R146 needed assistance of d to chair/chair to bed stand. A change was made to ance of one at all times. The	F 157			

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		AND HUMAN SERVICES			FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245210	B. WING		08/:	31/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	Continued From pa "fall noted".	ige 8	F 157	7		
	summary, identified [independent] with a self-cares walker bu	all mobility, ambulation, and ut has had a decline over the t SBA [stand by assist] with				
	thought she could c bathroom where sh Resident landed on head on built in dre with call light close	o.m. by RN-B "Resident do it herself and ambulated to he fell in the doorway. In her back after hitting her esser on way down. Put in bed at hand. Close monitor." was "Hit back/top of head. o as result."				
	- 5/23/16 at 4:16 p.i back of head dry, n	m. by LPN-A "Laceration on to infection noted."				
	very weak and shall	m. by LPN-A "Res [resident] ky today. Stayed in bed all v for dinner, appetite poor. Will nonitor."				
	roommate called ou She heard a loud co entered the room a face down, unrespo rolled to her back a	.m. by LPN-A "Res [resident] ut for a nurse from the hallway. rash that woke her up. Writer ind found res [resident] lying ponsive. Res [resident] was ind sternal rub tried. Resp int, pulse absent, res [resident]				
	dated 5/23/16, at 9: mark on box with o	ty Resident Occurrence Report :45 p.m. identified a check bserved on floor, "bleeding on edical attention required, no;				

If continuation sheet Page 9 of 28

		AND HUMAN SERVICES				FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING			08/:	31/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE MI	NNETONKA SHORES	;			527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	first aid required, no identified R148 was respond verbally an The physician was p.m. Review of the PT D 5/19/16 to 5/23/16 i 5/23/16: "PTA [phys nursing of pt [patier and shakiness. Du got a w/c [wheelcha very weak after 2nd in speaking." The PT-Therapist F Summary dated 5/2 passed away unexp decline over the pat "Skilled services pro included There ex [training And pt educ patient's abilities in and ADLs prior to fu pt passing away." When interviewed of program manager (receiving therapy fm On 5/18/16, R148 w independent, and w distances was to ha the resident (R148) assistance of one fo transferring and am	b; witness, no. The form a unconscious, unable to ad "res [resident] had expired." notified on 5/23/16 at 11:00 vaily Treatment Notes from dentified the following: sical therapy assistant] alerted nt] grey coloring, weakness e to pt increased weakness air] for pt." It also noted "Pt d fall. Pt shaky even with voice Progress & Discharge 24/16, identified "Pt [patient] bectedly last night following st few days." It also noted ovided since start of care therapeutic exercises], gait cation which improved Amb [ambulation], transfers unctional decline leading up to on 8/31/16, at 2:09 p.m. rehab (RPM) stated R148 was om 5/18/16, through 5/23/16. vas assessed as being when ambulating all longer ave assist of one. On 5/23/16, changed, and needed or all mobility (including	F	157			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/03/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245210	B. WING	ì		08/	31/2016
NAME OF	PROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE M	INNETONKA SHORES	3			4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	5/22/16, R148 had were expected to n neuro's, which they notification would b time a call is warrar change in cognition when medical atten is required. The do had a hematoma w documented in the would be called onl At 2:43 p.m. the dir entered and stated be called unless sta bleeding, adding th expect from the sta When interviewed of licensed practical n unsure if R148 had reviewing the notes definitely notify the was unable to locat physician on 5/23/1 hematoma and lace complaints of not fe also stated from rea R148 had a change status the MD shou When interviewed of medical doctor (ME on 5/23/16 at 1:05 a was in the office to was reviewed by he fax identified R148 MD-A denied any k status. "We didn't l	a wound on her head. Staff notify the physician and start v did. RN-B stated a fax be acceptable, and the only nted is when there there was a n or a change in neuro's or ntion from the emergency room becumentation identified (R148) vith some bleeding. This was record and the physician ly if the bleeding did not stop. rector of nursing (DON) a physician would not need to aff were unable to stop the is is what the physician would aff. on 8/31/16, at 3:22 p.m. nurse (LPN)-A stated he was any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the 16, following the fall with a eration on 5/22/16, and eeling well on 5/23/16. LPN-A ading the progress notes, e in status, with a change in	F	157			

Facility ID: 00271

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		AND HUMAN SERVICES				FORM	10/03/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING			08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	\$			527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	routine fax to sign of next was a notificat did we see a chang bleeding." MD-A st communication, and decline in status, no but "given her histo Although R148 shor status after her fall 5/23/16, the facility comprehensively as changes and failed possible medical int A facility policy date Change of Conditio indicated staff was time there was a sig also directed staff to record the time call what was reported a policy included a "lis what should be repo- injury requiring first A facility policy date Prevention and Mar review date 2/16, id trauma or unwitnes not able to state if the alert the physician of changes. It also dir into the medical reco- appearance at the to response to event,	orders for therapy, and the cion of her death. "Nowhere ge in neuro status or the cated there was a failure in d it appeared R148 had a ot necessarily a head bleed, ry you gotta wonder." wed a change in her medical and subsequent death on had not recognized and ssessed these medical to contact the physician for terventions for R148. ed as reviewed on 2/16, on Physician Notification Policy, to notify the physician any gnificant change in condition. It o document in the medical ed, the person spoken to, and their response if any. The st of possible examples of orted", which identified any aid, and any falls. ed as reviewed 2/16, Fall nagement Program Policy dentified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry cord including patient time of discovery, patient evidence of injury, location, otification, responsible party	F 1	57			

Facility ID: 00271

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	COR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION	OMB NO.	0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	· · /	PLETED	
		245210	B. WING _		08/	31/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 241	Continued From pa	age 12	F 24	11			
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 24	1		10/7/16	
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.					
	by: Based on observa review, the facility f	NT is not met as evidenced tion, interview and document ailed to ensure a dignified consistently provided for 1 of 3 riewed for dignity.		Corrective Action: To correct th practice for resident #80, LSW interviewed resident to make su have proper understanding of w the resident would prefer to rise	re we nat time		
	Findings include:			bed. Weekly check-ins with Res Services for this resident will oc	sident cur to		
	7/25/16, identified F required extensive	imum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility,		ensure resident needs are being Corrective Action as it applies to	other		
	During interview on stated she did not f dignity because it s lag of time," in getti dressing. R80 stat	endent on staff for transfers. 8/29/16, at 4:24 p.m. R80 eel staff treated her with seemed, "Like there's always a ing assistance with cares and ed the staff often start helping		residents: The policy and proce call light response and dignity w reviewed and are current. All re preferences are assessed upon admission, minimally quarterly a indicated with a change in reque services from family or resident.	ere sident nd as st of All staff		
	so R80 has to, "Lay someone to help fir this happens, "All th "Rejected and unca			are trained on timely response of lights and meeting resident requ hire and minimally annually with training. An in-service will be pro- review the importance of residen preferences and Dignity policy d	ests upon annual ovided to ot uring the		
	room with her call I practical nurse (LP turned off R80's ca	a.m. R80 was in bed in her ight turned on. Licensed N)-B entered the room and Il light. LPN-B applied a s and asked her, "Are you		week of October 3, 2016. This to be discussed at resident council upcoming in October as to resid preference and timeliness of set Household residents will be inte	ent vices.		

Facility ID: 00271

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							0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· /	E SURVEY PLETED
		245210	B. WING _			08/3	31/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORE	S		-	527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 241	waiting to get up," would inform the n 7:57 a.m. R80 aga outside the room. turned off the call I would be coming," applied a warm wa the room. At 8:25 a.m. R80 r assistance being o ready for the day a stated she was, "W had been waiting fe [a.m.]." R80 stated help had happened "Lonelier because dining room]." At 8 after observation b room and helped h 9:28 a.m. R80 was the dining room an with only two other room at a different breakfast alone in When interviewed stated R80 had co helped timely in the residents sometim periods if they are typically, "Really be During interview of	R80 stated she had, "Been to which LPN-B stated she ursing assistant (NA) staff. At in turned on her call light LPN-B entered the room and ight and told R80 the NA staff "In a minute." LPN-B then ashcloth to R80's eyes and left emained in bed without any offered to help her get up or as she had requested. R80 Vaiting on my aides [NA]," and or help to get up, "since 7:30 d having to wait this long for d before, and it makes her feel, I have to eat by myself [in the B:29 a.m. (thirty five minutes began) NA-A entered R80's her get dressed for the day. At a assisted out of her room to d seated at a table by herself, residents seated in the dining table. R80 was served the dining room. on 8/31/16, at 9:34 a.m. NA-A mplained about not being e morning before to her, and es have to wait for longer short staffed because they are ehind," then. n 8/31/16, at 10:03 a.m. LPN-B	F 24	41	LSW to learn preference on what tin residents would like to get up and ge sleep each day. A committee has be formed to discuss ongoing staffing patterns in the morning/evening and we can best meet our residents preferences. Reoccurrence will be prevented by: Weekly Audits will be done on 10% residents to ensure resident s preferences are being met when it of to preferred wake times and the time they are going to bed. Residents preferred wake times will be added NAR team sheets. Audits of timely response rates will also be conducte 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 for review. c. The Administrator will report audits to QA Team. QA will determine freque audits c. The Administrator will be respon for compliance.	o to been d how of the comes es to ed to et : : : o the ency of	
	stated staff, "Try to	get them [residents] as we les R80, "Has to wait a little bit"					

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		& MEDICAID SERVICES	0.44			<u>). 0938-039</u>	
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTIO		TE SURVEY	
		245210	B. WING			3/31/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE SPRING PARK,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 241	Continued From pa	age 14	F 2	41			
	clinical coordinator should not have to be helped with care anyone to wait a lo	on 8/31/16, at 12:20 p.m. LPN (LPN)-C stated residents wait for extended periods to es adding, "We don't ever want ng period of time," because, and they need to feel trust in					
F 282 SS=D	resident should be an environment tha and/or enhanceme life."	licy dated 12/2014, identified cared for, "In a manner and in at promotes maintenance nt of each resident's quality of RVICES BY QUALIFIED ARE PLAN	F 2	32		10/7/16	
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of					
	by: Based on observa review, the facility f interventions to pro residents (R80) rev Findings include:	NT is not met as evidenced tion, interview and document failed to implement care plan prote skin integrity for 1 of 4 viewed for pressure ulcers.		resident 80, were not bei corrected ar re-educated care plan wa	Action: To correct this for upon identification that heels ing floated, it was immediatel nd staff involved were I on resident plan of care. Th as reviewed and is current. Sheet was updated to match interventions.	У	
	7/25/16, identified l required extensive	nimum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility, pressure ulcer formation.		residents: T	Action as it applies to other The policy and procedure for as reviewed and is current. A	.11	

Facility ID: 00271

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245210 **B** WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 15 F 282 "Limited physical mobility in bed," and R80 had, and My Best Day/assignment sheet are "Potential for alteration in skin integrity." The care reviewed minimally quarterly and with plan directed staff to, "Keep heels elevated in change in status and updated with any bed." changes. We will audit the team sheets to make sure the current team sheets match During observation of morning care on 8/31/16, at the care plan for each resident. When 8:29 a.m. R80 was laying in her room in bed. there is a change in care the Clinical Nursing assistant (NA)-A pulled back R80's Coordinators (or designee) will update the bedding exposing R80's legs and feet. R80's team sheets and the care plan. There will heels were not being floated with any devices or be an in-service regarding the process of pillows, instead they were directly on the updating of care plan and team sheets for mattress. R80 stated, "My heel hurts," and the all nursing the week of October 3, 2016. back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 Reoccurrence will be prevented by: was assisted to the bathroom and NA-A stated Weekly Audits will be completed by R80 reddened heel, "Kind of feels soft." Clinical Coordinators. They will chose 10% of the residents each week to make When interviewed on 8/31/16, at 9:34 a.m. NA-A sure care plans match team sheets and stated R80's heels were not being floated when that the services indicated on the plan of she removed her bedding and her right heel was care are being followed. reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when The Correction will be monitored by: a. The audits will be given to the Clinical she would assist her with morning cares. Further, Administrator for review. NA-A stated R80's heels have been red in the morning before when they are not floated, "Their b. Administrator will report audits to the usually red." QA Team. QA will determine frequency of audits During interview on 8/31/16, at 9:52 a.m. licensed c. The Clinical Administrator will be practical nurse (LPN)-B stated the care plan was responsible for compliance. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 10/03/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY	
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED	
		245210	B. WING		08/3	31/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE			
LAKE M	INNETONKA SHORES	3	SPRING PARK, MN 55384				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 282	A facility Care Plan 4/2016, identified a "Ensure the resider required to maintain	ge 16 Policy and Procedure dated care plan was used to, nt has the appropriate care n or attain the resident's cticable function possible."	F 28:	2			
F 309 SS=G	483.25 PROVIDE C HIGHEST WELL B Each resident must	CARE/SERVICES FOR EING t receive and the facility must	F 309	9		10/7/16	
	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.						
				Resident #148 expired on 5/23/201 Corrective Action as it applies to oth residents: The policy and procedure assessment and provider notification reviewed and is current. All residen assessed upon admission, minimall quarterly and as needed with change condition. All residents with change condition are reviewed with IDT dail physicians updated timely as per clin indications and per policy. The facil EMR also alerts nurses to documen and report of NARs to potential chan status each shift. An in-service for nursing staff will be presented during week of 10/3/2016 related to recogn and assessment of status change a timely notification of physician/ provi-	er es for n was ts are y e of e of y and nical lity tation nge in g the nition nd		

Facility ID: 00271

If continuation sheet Page 17 of 28

		(¥2) MI II	י יפוד				
	IDENTIFICATION NUMBER:				· · ·	PLETED	
	245210	B. WING			08/31/2016		
PROVIDER OR SUPPLIER							
NNETONKA SHORES	3						
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULI) BE	(X5) COMPLETION DATE	
R148's Comprehend dated 5/18/16, iden person, place and t consciousness as a status noted weakn for falls. R148's Individual R 5/18/16, identified F ambulation with use assist of one for tra It also noted R148 y care plan failed to a The Physical Thera 5/18/16, identified r in walking as the tra of care as 5/18/16. for falls and weakn month. R148 was f weakness, fatigue a impacting ability to perform activities of independently. R14 left knee feeling like The facility Therapy Maintenance Progr identified under Wa room, A1 [assist of to all destinations." Physical Therapist A Resident Occurre	A sive Data Collection form tified R148 was oriented to ime, with level of alert. Further, the neurological bess and a history of and risk resident Care Plan dated R148 was independent with e of a walker, and required insfers until seen by therapy. was alert and oriented. The address the risk for falls. Apy (PT) Plan of Care dated muscle weakness and difficulty eatment diagnosis, with a start It also noted hospitalization ess, with three falls in the past noted to have complaints of and impaired balance ambulate, transfer and f daily living (ADLs) safely and 8 noted significant fatigue and e it would buckle with gait. / to Nursing Functional am form dated 5/18/16, s "Independent Toilet, Bed to Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] This form was completed by (PT)-A.	F3	309	The information presented will rev policy on reporting Change of Con and Policy on Falls. At this in-serv will review elnteract tools, and the reporting of a Significant Change p note. This will ensure ongoing and consistent monitoring of any change condition is completed with medica intervention. Reoccurrence will be prevented by a. Audits for significant change will completed in daily IDT meeting. Al will be reviewed for significant change notification of provider, Administra family. b. 24 hour report will be reviewed of Clinical Coordinators to check for in condition. The nurse in charge of building will be reviewing on the weekends. The Correction will be monitored b a. The audits will be given to the C Administrator for review. b. Administrator for review. b. Administrator will report audits to QA Team. QA will determine frequ audits c. The Clinical Administrator will be	iew the dition rice staff progress ge in al r: I be I falls nge. I falls nge. tor, and daily by change of the wy: linical o the iency of		
	RS FOR MEDICARE OF DEFICIENCIES FORRECTION PROVIDER OR SUPPLIER INNETONKA SHORES SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From part R148's Comprehend dated 5/18/16, iden person, place and t consciousness as a status noted weakn for falls. R148's Individual R 5/18/16, identified F ambulation with use assist of one for tra It also noted R148 care plan failed to a The Physical Thera 5/18/16, identified r in walking as the tra of care as 5/18/16. for falls and weakn month. R148 was weakness, fatigue a impacting ability to perform activities o independently. R14 left knee feeling like The facility Therapy Maintenance Progr identified R148 was Chair/Chair to Bed, identified under Wa room, A1 [assist of to all destinations." Physical Therapist A Resident Occurre 6:00 p.m. identified	DF CORRECTION IDENTIFICATION NUMBER: 245210 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	AS FOR MEDICARE & MEDICAID SERVICES FOR DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245210 B. WING PROVIDER OR SUPPLIER 245210 B. WING NNETONKA SHORES IDENTIFICATION NUMBER: ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 17 F148'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. F148'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 identi	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL A: BUILDING. 245210 B. WING PROVIDER OR SUPPLIER 245210 B. WING NNETONKA SHORES S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 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. F 309 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 R	Residence Resident Composition Composition Resident Composition (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 245210 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH OPERCIENCY MUST BE PRECIDED BY FULL PRETW REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH OPERCIENCY MUST BE PRECIDED BY FULL PRETW REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 R148'S Comprehensive Data Collection form 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 independent with ambulation with use of a walker, and required assist of one for transfers until seen by therapy. It also noted R148 was independent with ambulation with use of a walker, and required assist of no for transfers until seen by therapy. It also noted R148 was independent with ambulation with use of a walker, and required assist of no for transfers and perform activities of daily living (ADLS) safely and independently. R148 noted significant tatigue and perform activities of daily living (ADLS) safely and independently. R148 noted significant tatigue and left knee feeling like it would buckle with gait. The Correction will be reviewed of Clinical Coordinators to chack for r in condition. The audits will be eviewed by a. Administrator will report audids to CAmministrator will report audits to ChairChair	RS FOR MEDICARE & MEDICAID SERVICES OMB NO. OF DEFICIENCIES FOORECTION (X) PROVIDERSUPPLIERCLA A BUILDING (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) AUTHOR AND A BUILDING (X2) AUTHOR AND	

Facility ID: 00271

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	тірі		FORM MB NO.	10/03/2016 APPROVED 0938-0391 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
		245210	B. WING			08/31/2016		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE MI	NNETONKA SHORES	;			4527 SHORELINE DRIVE SPRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	room, knees gave of floor by staff. Medi- voicemail at 6:35 p. A Resident Occurre 9:00 p.m. identified floor, noting a fall w and laceration to th report noted medica including "pressure compress to hemat was notified by fax hours and 10 minut R148 identified she hurt, and was holdin noted after the fall w Review Form dated of the residents pos The picture identified dresser, which was television. Review of the facilit monitoring tool use neurological sympto from 9:00 pm thru 5 no changes in neur 9:00 p.m. thru 5/23/1 R148's right and lef but identified there neuro check even t slow to respond on at 9:00 a.m. and 1:0 fell hitting her head laceration. There w Check Flow sheet a there was no date in	out, and was lowered to the cal provider was notified via	F	309				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/03/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245210	B. WING			08/	31/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAKE MI	NNETONKA SHORES	;			4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 19	F:	309	9		
	showed no changes reactive to light.	s, and pupils were equal and					
	to the the physician 5/23/16, which was form identified: "6:0 dining room 'my kno assistant registered to a sitting position "9:00 pm. Residen herself' and ambula she fell, hitting her I head. VS [vital sign checks] are being n after fall was 79/49. 135/87" There wa to the physician foll was marked, "Note	Transmittal Form was faxed with a faxed date identified as hand written on the form. The 0 p.m. while ambulating to ees gave out'. NAR [nursing I] caught her and lowered her on floor." It also identified: t 'thought she could do it atted to the bathroom where head. There is a bump on s] and neuro's [neurological nonitored. Blood pressure . It was then 106/74 then as no further data on the form owing the ellipsis. This form d" and signed by the physician ed back to the facility on h.					
	was reviewed. The the occurrence, how interventions of res with all transfers, ar increased weaknes (international norma for measurement or clotting, was within date or time identifi	Falls Follow Up Form for R148 form lacked date or time of wever identified long term ident changed to assist of one nd therapy notified of s. Neuro at baseline and INR alized ratio), a laboratory test f anticoagulants for blood normal limits. There was no ed of when this form was ong term interventions.					
	Program dated 5/23 status for R148. R1	ng Functional Maintenance 3/16, identified a change in 48 needed assistance of one chair/chair to bed transfers					

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		AND HUMAN SERVICES			FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245210	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	INNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	and sit to stand. A c with assistance of c completed by physi R146's Care Confe 5/23/16, identified: did hit head." It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is r FWW [four wheeled resident in moderat SBA [stand by assis Review of R148's p through 5/24/16, ide - 5/23/16 at 10:03 a "fall noted". - 5/23/16 at 8:23 an identified "Resident mobility, ambulation has had a decline of SBA [stand by assis walker]." - 5/23/16 at 12:47 p thought she could of bathroom where sh Resident landed on head on built in dre with call light close Injury description w Bleeding and bump	change was made to walking one at all times. The form was ical therapy assistant-A. Frence Summary dated "[R148] had 2 falls on Sunday, o noted: "Had increase in weekend and increased ummary noted: "Resident was vith all mobility, ambulation, are but has had a decline over now SBA [stand by assist] with d walker]. Balance score puts te risk for falls. Resident is st] for dressing/toileting." Forogress notes dated 5/18/16, entified the following: a.m. Fax received from MD, m care conference summary, t was ind [independent] with all n, and self-cares walker but over the weekend and is not st] with FWW [four wheeled b.m. by RN-B "Resident do it herself and ambulated to be fell in the doorway. n her back after hitting her isser on way down. Put in bed at hand. Close monitor." vas "Hit back/top of head.	F 30	99		

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		AND HUMAN SERVICES			FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245210	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE MI	NNETONKA SHORES	3		527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa back of head dry, n - 5/23/16 at 6:16 p. very weak and shal shift, had room tray cont [continue] to m -5/23/16 at 22:26 p. roommate called ou She heard a loud cu entered the room a face down, unrespor rolled to her back a [respirations] abser DNR/DNI." Review of the facilit dated 5/23/16, at 9: mark on box observ R [right] cheek." Me first aid required, no identified R148 was respond verbally ar The physician was p.m. Review of the PT D 5/23/16 identified th 5/23/16: "PTA [phys nursing of pt [patier and shakiness. Du got a w/c [wheelcha	age 21 no infection noted." m. by LPN-A "Res [resident] ky today. Stayed in bed all v for dinner, appetite poor. Will nonitor." .m. by LPN-A "Res [resident] ut for a nurse from the hallway. rash that woke her up. Writer and found res [resident] lying ponsive. Res [resident] lying ponsive. Res [resident] was and sternal rub tried. Resp nt, pulse absent, res [resident] ty Resident Occurrence Report :45 p.m. identified a check ved on floor and, "bleeding on edical attention required, no; o; witness, no. The form s unconscious, unable to nd "res [resident] had expired." notified on 5/23/16 at 11:00	TAG F 309	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
	The PT - Therapist Summary dated 5/2	Progress & Discharge 24/16, identified: "Pt [patient] pectedly last night following				

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		AND HUMAN SERVICES				FORM	10/03/2016 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245210	B. WING	i		08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MINNETONKA SHORES					1527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	decline over the pas "Skilled services pro- included There ex [training and pt [pati- patient's abilities in and ADLs prior to fu pt passing away." When interviewed of program manager (receiving therapy fro- On 5/18/16, R148 v independent, and w distances was to have the resident (R146) assistance of one for transferring and am When interviewed of registered nurse (R 5/22/16, R148 had were expected to no neuro's, which they notification would be time a call is warrar change in cognition when medical atten is required. The do had a hematoma w documented in the would be called only At 2:43 p.m. the dire entered and stated be called unless sta bleeding, adding thi expect from the sta	st few days." It also noted: ovided since start of care (therapeutic exercises], gait ent] education which improved Amb [ambulation], transfers unctional decline leading up to on 8/31/16, at 2:09 p.m. rehab (RPM) stated R148 was om 5/18/16, through 5/23/16. was assessed as being when ambulating all longer ave assist of one. On 5/23/16, o changed, and needed or all mobility (including hbulation). on 8/31/16, at 2:29 p.m. N)-B stated after the fall on a wound on her head. Staff otify the physician and start of di. RN-B stated a fax e acceptable, and the only inted is when there was a n or a change in neuro's or ation from the emergency room ocumentation identified (R148) ith some bleeding. This was record and the physician y if the bleeding did not stop. ector of nursing (DON) a physician would not need to aff were unable to stop the is is what the physician would	F 3	309			

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		AND HUMAN SERVICES			FORM	10/03/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245210	B. WING		08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MINNETONKA SHORES				1527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	unsure if R148 had reviewing the notes definitely notify the was unable to locat physician on 5/23/1 hematoma and lace complaints of not fe also stated from rea R148 had a change in status the medica notified. When interviewed of stated a fax was re- a.m. at the office, b receive it at that tim her colleague on 5/ R148 had a bump of knowledge of a cha didn't know that she received from the fa sign orders for ther notification of her d did we see a chang bleeding." MD-A st communication, and decline in status, no but added, "Given h R148 was admitted was independent w bed to chair, sit to s only needed staff a more than 100 feet 5/23/16, following th R148 hit her head. medical status less R148 complained s	age 23 any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the 6, following the fall with a eration on 5/22/16, and eeling well on 5/23/16. LPN-A ading the progress notes, e in status, and with a change al doctor (MD) should be on 8/31/16, at 4:46 p.m. MD-A ceived on 5/23/16, at 1:05 but nobody was in the office to ne. The fax was reviewed by '23/16. The fax identified on the head. MD-A denied any ange in status and stated, "We e was bleeding." Notification acility included a routine fax to apy, and the next was a leath. MD-A added, "No where ge in neuro status or the tated there was a failure in d it appeared R148 had a ot necessarily a head bleed, ner history you gotta wonder." It to the facility on 5/18/16, and rith; toileting, transferring from stand, walking in her room and ssistance of one, if ambulating . R148 sustained 2 falls, on he fall on 5/23/16 at 9:00 p.m. R148 had changes in her than 24 hours after the fall. she was not feeling very well, shaky and needed staff	F 309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/03/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245210	B. WING	i		08/	31/2016	
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE MI	NNETONKA SHORES	i			4527 SHORELINE DRIVE SPRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 309	though she was pre R148 also needed a ambulation at all tim assistance of one s feet, and had neuro status 12 hours after showed a change in fall on 5/22/16, the comprehensively re changes and failed possible medical int actual harm for R14 A facility policy date Change of Conditio indicated staff was time there was a sig also directed staff to record the time call what was reported a policy included a "lis what should be repo- injury requiring first A facility policy date Prevention and Mar review date 2/16, id trauma or unwitnes not able to state if the alert the physician of changes. It also dir into the medical rec appearance at the to response to event,	asfers and toileting even eviously independent with this. additional staff assistance for nes, which was a change from taff for long distances of 100+ logical changes in her pupil er her fall. Although R148 in her medical status after her facility had not recognized and assess these medical to contact the physician for terventions which resulted in 48 who subsequently died. Id as reviewed on 2/16, in Physician Notification Policy, to notify the physician any gnificant change in condition. It b document in the medical ed, the person spoken to, and their response if any. The st of possible examples of orted", which identified any aid, and any falls. Id as reviewed 2/16, Fall hagement Program Policy entified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry ord including patient ime of discovery, patient evidence of injury, location, otification, responsible party	F	309				
F 314	483.25(c) TREATM		F	314			10/7/16	

		AND HUMAN SERVICES				FORM /	10/03/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245210	B. WING			08/3	31/2016
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	3			527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 314 SS=D	PREVENT/HEAL P	-	F:	314			
	resident, the facility who enters the facil does not develop p individual's clinical they were unavoida pressure sores rece	must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and					
	by: Based on observat review, the facility fa were implemented	NT is not met as evidenced tion, interview and document ailed to ensure interventions to reduce the risk of pressure 1 of 4 residents (R80) ure ulcer care.			To correct this for resident #80, staft completed a Braden and Skin Risk Assessment to make the Care Plan correct and updated care plan/Team Sheets.		
	7/25/16, identified F required extensive and was at risk for R80's Skin Risk and 7/20/16, identified F signs and symptom sensation of lower e assessment identifi developing pressure	imum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility, pressure ulcer formation. d Braden assessment, dated R80 to have fragile skin and is of neuropathy with, "Tingling extremity or feet." Further, the ed R80 was at, "Mild Risk" or e ulcers. red 8/3/16, identified R80 had,			Corrective Action as it applies to other residents: The policy and procedure skin risk and pressure ulcer preventi- was reviewed and is current. To pre- reoccurrence for other residents we pull a report of all pressure issues in Click Care and audit the Care Plan to make sure the proper instructions ar Team Sheets. An in-service will be h- reviewing the Skin at Risk Policy to fi- floating of heels and points of pressure The Team Sheets will be reviewed to insure all areas of concern are addres All residents are assessed upon admission for skin risk and the care	e for on vent Will Point o e on eld ollow ure. o essed.	
	"Limited physical m "Potential for altera	obility in bed," and R80 had, tion in skin integrity." The care o, "Keep heels elevated in			and my best day/ team sheet update interventions. All residents are asse minimally quarterly and with change	d with ssed	

Facility ID: 00271

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245210	B. WING		08/31/2016
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMPLE
F 314	bed." R80's most recent lidentified R80 had heels were describe During observation 8:29 a.m. R80 was Nursing assistant (libedding exposing F heels were not beir pillows, instead the mattress. R80 stat back of her heel wa were no visible ope was assisted to the R80 reddened heel When interviewed of stated R80's heels she removed her berreddened. NA-A stat the past where R80 she would assist he NA-A stated R80's morning before who usually red." During interview on licensed practical n (LPN)-B stated R80 pressure ulcers" be and incontinence. unaware of any cor heels which would aware of anything w stated if staff attem refused, it should b	Body Audit dated 8/15/16, no current pressures and her	F 31	 4 status impacting risk and the care and my best day/ team sheet are to reflect interventions or changes risk. Reoccurrence will be prevented by Clinical Coordinator or designee at the care plan, assessment and tea sheets to ensure all of the informa accurate. Staff will audit 10% of the residents each week to make sure areas are matching and that the interventions are in place. The Correction will be given to the CAdministrator for review. b. The Clinical Administrator will results to the QA Team. QA will define frequency of audits. c. The Administrator will be responded to the compliance. 	updated in skin v: uditing am tion is ne all by: Clinical eport termine

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/03/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245210	B. WING			08/:	31/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	;			527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	previous night or m When interviewed a LPN-B stated R80's floated while she was should have docum weren't. A facility Skin Risk a directive to, "Impl and to provide appr for pressure ulcers/ standards of care." general care guidel	een floated during the	F	314			

Facility ID: 00271

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		AND HUMAN SERVICES						APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0		. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST				E SURVEY IPLETED
		245210	B. WING _				08/	/31/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, 2	ZIP CODE		
LAKE MI	NNETONKA SHORES	5			DRELINE DRIVE PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00				
F 156 SS=D	was completed by s Department of Heal Shores was found to the regulations at 4 requirements for Loc The facility's plan of as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substar regulations has bee your verification. 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the \$1919(e)(6) of the A made prior to or up resident's stay. Re any amendments to writing. The facility must inf	1/16, a recertification survey surveyors from the Minnesota Ith (MDH). Lake Minnetonka to not be in compliance with 2 CFR Part 483, subpart B, ong Term Care Facilities. If correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in	F 15	56				9/30/16
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE			(X6) DATE
Electron	ically 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.

PRINTED: 10/04/2016

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/04/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245210	B. WING			08/	31/2016
NAME OF	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	;			4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	of admission to the resident becomes e items and services facility services und which the resident r other items and ser and for which the re- the amount of charg inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admis the resident's stay, facility and of charg including any charg under Medicare or I The facility must fun legal rights which in A description of the for establishing elig the right to request 1924(c) which dete non-exempt resour- institutionalization a spouse an equitable cannot be consider toward the cost of t medical care in his down to Medicaid e	nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and at when changes are made to ces specified in paragraphs (5) a section. Form each resident before, or asion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate. Thish a written description of acludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending	F 1	156			

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		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245210	B. WING _		08/3	31/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE				
	NNETONKA SHORES			SPRING PARK, MN 55384				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORR(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SIREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE AF DEFICIENCY)			D BE	(X5) COMPLETION DATE		
F 156	groups such as the agency, the State lie ombudsman progra advocacy network, unit; and a stateme complaint with the S agency concerning misappropriation of facility, and non-cor directives requireme The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi- receive refunds for such benefits. This REQUIREMEN by: Based on interview facility failed to pro-	State survey and certification censure office, the State and the protection and and the Medicaid fraud control int that the resident may file a State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance ents. orm each resident of the d way of contacting the ble for his or her care. ominently display in the facility and provide to residents and ssion oral and written ow to apply for and use caid benefits, and how to previous payments covered by NT is not met as evidenced and document review, the vide the required Notice of erage for 1 of 3 residents	F 15	Resident 93 was discharged prio adequate notice given related to f and resident's wishes to discharg than anticipated end date of thera	amily e earlier			
	Findings include: R93's progress note would be completin to assisted living on	e dated 7/13/16, identified R93 g therapy and discharge back 17/15/16. R93 had, "No		Corrective Action as it applies to c residents: The policy and proced Medicare Denials was reviewed a current.	other ure for nd is			
	further recommend	ations for continued therapy."		To prevent reoccurrence for other residents the criteria for denial for				

Facility ID: 00271

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PRINTED: 10/04/2016 FORM APPROVED

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		i	СОМ	PLETED
		245210	B. WING		08/3	31/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 156	R93's medical reco no evidence R93 h Medicare Non-Cov required when their ended. During interview or social worker (LSW nursing home for th Medicare Part A co therapy services an discharge on Satur assisted living wou weekend. LSW-A with R93's family to Friday, 7/15/16, ins not provided a Noti	ord was reviewed. There was ad been provided a Notice of erage (CMS-10123) as r Medicare coverage was a 8/31/16, at 3:55 p.m. licensed <i>I</i>)-A stated R93 admitted to the herapy services under verage. R93 completed his ad was originally planned to day, 7/16/16, however the ld not accept him on the stated a decision was made o move up his discharge to stead. LSW-A stated R93 was ce of Medicare Non-Coverage use R93, "Chose to go on his	F 156	Medicare benefits is reviewed daily meetings. In-service for this group held the week of 9/26/2016. Spec training and tool kits were created responsible for providing notices. Reoccurrence will be prevented by will be done weekly by the Resider Services Director (LSW) or design audits will be reviewed monthly to for criteria of discharge to make su 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 QA Team. QA will determine frequ audits	will be ific for staff r: Audits nt ee. The check ure to the iency of	
F 157 SS=D	consult with the resknown, notify the resknown, notify the resort accident involving the injury and has the printervention; a sign physical, mental, or deterioration in heat status in either life clinical complication significantly (i.e., a		F 157	c. The Administrator will be respo for compliance.	onsible	10/7/16

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 10/04/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245210	B. WING			3/31/2016
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE MI	NNETONKA SHORES	;			527 SHORELINE DRIVE PRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	treatment); or a dec the resident from the §483.12(a). The facility must als and, if known, the re or interested family change in room or re specified in §483.1 resident rights under regulations as spect this section. The facility must react the address and phe legal representative This REQUIREMEN by: Based on interview facility failed to infor- pertinent information after the resident fer reviewed for falls. Findings include: R148's Admission F identified she was a 5/18/16 with diagno disease, hypo tensi history of falls. The Data Set identified for medication (blood the medication in the later the facility is a set identified for the facility in the later the facility in the later the facility in the later the facility is the later the facility falle for the facility falled for the facility falle for the facility falled for the facility falled for the facility falled for the facility falled for the facility falle for the facility falled for the facil	o commence a new form of cision to transfer or discharge re facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or iffied in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced r and document review, the rm the resident's physician of n about the resident's status ell for 1 of 2 residents (R148) Record sheet (undated) admitted to the facility on ses of end stage renal on, difficulty walking and a 5/23/16 admission Minimum R148 was on an anticoagulant hinner), and had received the st 6 days.	F 1	57	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	
	Comprehensive Da	ta Collection form dated			and assessment of status change and	

Facility ID: 00271

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				ייסו			0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245210	B. WING			08/3	31/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE M	NNETONKA SHORES	3			527 SHORELINE DRIVE PRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE	
F 157	place and time, witi alert. Neurological history of and risk f R148's Individual F 5/18/16, identified F ambulation with use assist of one for tra- It also noted R148 care plan failed to a The Physical Thera 5/18/16, identified r in walking as the tro of care as 5/18/16. for falls and weakn month. R148 was weakness, fatigue impacting ability to perform activities o independently. R14 left knee feeling like The facility Therapy Maintenance Progr identified R146 was Chair/Chair to Bed, identified under Wa room, A1 [assist of to all destinations." Physical Therapy-A A Resident Occurre 6:00 p.m. identified without injury. R148	R148 was oriented to person, h level of consciousness as status noted weakness and a for falls. Resident Care Plan dated R148 was independent with e of a walker, and required ansfers until seen by therapy. was alert and oriented. The address the risk for falls. apy (PT) Plan of Care dated muscle weakness and difficulty eatment diagnosis, with a start It also noted hospitalization ess, with three falls in the past noted to have complaints of and impaired balance ambulate, transfer and f daily living (ADLs) safely and t8 noted significant fatigue and e it would buckle with gait. y to Nursing Functional am form dated 5/18/16 s" Independent Toilet, Bed to , Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] This form was filled out by	F 1	57	timely notification of physician/ proteam including information to be reached information presented will revipolicy on reporting Change of Compand Policy on Falls. At this in-server will review elnteract tools, and the reporting of a Significant Change prote. This will ensure ongoing and consistent monitoring of any change condition is completed with medication. Reoccurrence will be prevented by a Audits for significant change we completed in daily IDT meeting. All will be reviewed for significant change we completed in daily IDT meeting. All will be reviewed for significant change we completed in daily IDT meeting. All will be reviewed for significant change we completed in daily IDT meeting. All will be reviewed for significant change we completed in condition. The nurse in condition. The nurse in condition. The nurse in condition will be reviewing on weekends. The Correction will be given to the C Administrator for review. b. Administrator for review. b. Administrator will report audits to QA Team. QA will determine frequations and the composition of proving compliance for ongoing compliance of the sponsible for ongoing compliance of the composition of provider composition.	ported. ew the dition ice staff orogress l je in al : ill be falls nge. d daily or charge the y: linical o the ency of		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING			08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	INNETONKA SHORES	3			527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	voicemail at 6:35 p. A Resident Occurre 9:00 p.m. identified floor, noting a fall w and laceration to th report noted medic- including "Pressure compress to hemat was notified by fax fall. R148 identified head hurt, and was hand. BP noted afte Review of the facilit monitoring tool use neurological sympto from 9:00 pm thru 5 no changes in neur 9:00 p.m. thru 5/23 identified on 5/23/1 R148's right and let but identified there neuro check even t slow to respond on at 9:00 a.m. and 1: fell hitting her head laceration to the ba was another entry of sheet after the 1:00 no date identified but just "F changes, and pupil- light. A Facility Facsimile physician faxed on written on the form.	.m. of the fall. ence Report dated 5/22/16, at I R148 was observed on the vith injury, including hematoma he back/top of head. The al attention was required, to stop bleeding" and "Cold toma". The medical provider on 5/23/16 at 1:10 a.m. of the d she hit her head, and her a holding her head with one	F 1	57			

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		AND HUMAN SERVICES			FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245210	B. WING		08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	out'. NAR [nursing her and lowered he It also identified "9: could do it herself" bathroom where sh is a bump on head. [neurological check pressure after fall w then 135/87" The form to the physicia form was marked "1 physician on 5/23/1 facility on 5/23/16, a A Therapy to Nursir Program dated 5/23 status for R146 and one for toileting, be transfers and sit to walking with assista form was filled out I assistant-A. R148's Care Confe 5/23/16, identified F did hit head". It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is n FWW [four wheeled resident in moderat SBA [stand by assis Review of R148 pro	assistant registered] caught assistant registered] caught of to a sitting position on floor." 00 pm. Resident 'thought she and ambulated to the he fell, hitting her head. There VS [vital signs] and neuro's iss] are being monitored. Blood vas 79/49. It was then 106/74 ere was no further data on the an following the ellipsis. This noted" and signed by the 6, and faxed back to the at 8:29 a.m. ng Functional Maintenance 3/16, identified a change in d R146 needed assistance of d to chair/chair to bed stand. A change was made to ance of one at all times. The	F 157			

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		AND HUMAN SERVICES			FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING		08/:	31/2016
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	Continued From pa "fall noted".	ige 8	F 157	7		
	summary, identified [independent] with a self-cares walker bu	all mobility, ambulation, and ut has had a decline over the t SBA [stand by assist] with				
	thought she could c bathroom where sh Resident landed on head on built in dre with call light close	o.m. by RN-B "Resident do it herself and ambulated to he fell in the doorway. In her back after hitting her esser on way down. Put in bed at hand. Close monitor." was "Hit back/top of head. o as result."				
	- 5/23/16 at 4:16 p.ı back of head dry, n	m. by LPN-A "Laceration on to infection noted."				
	very weak and shall	m. by LPN-A "Res [resident] ky today. Stayed in bed all v for dinner, appetite poor. Will nonitor."				
	roommate called ou She heard a loud co entered the room a face down, unrespo rolled to her back a	.m. by LPN-A "Res [resident] ut for a nurse from the hallway. rash that woke her up. Writer ind found res [resident] lying ponsive. Res [resident] was ind sternal rub tried. Resp int, pulse absent, res [resident]				
	dated 5/23/16, at 9: mark on box with o	ty Resident Occurrence Report :45 p.m. identified a check bserved on floor, "bleeding on edical attention required, no;				

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		AND HUMAN SERVICES				FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING			08/;	31/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	;			527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	first aid required, no identified R148 was respond verbally an The physician was p.m. Review of the PT D 5/19/16 to 5/23/16 i 5/23/16: "PTA [phys nursing of pt [patier and shakiness. Du got a w/c [wheelcha very weak after 2nd in speaking." The PT-Therapist F Summary dated 5/2 passed away unexp decline over the pat "Skilled services pro- included There ex [training And pt educ patient's abilities in and ADLs prior to fu pt passing away." When interviewed of program manager (receiving therapy fr On 5/18/16, R148 v independent, and w distances was to ha the resident (R148) assistance of one for transferring and am	b; witness, no. The form a unconscious, unable to ad "res [resident] had expired." notified on 5/23/16 at 11:00 baily Treatment Notes from identified the following: sical therapy assistant] alerted at] grey coloring, weakness ar to pt increased weakness air] for pt." It also noted "Pt d fall. Pt shaky even with voice Progress & Discharge 24/16, identified "Pt [patient] bectedly last night following st few days." It also noted ovided since start of care (therapeutic exercises], gait cation which improved Amb [ambulation], transfers unctional decline leading up to on 8/31/16, at 2:09 p.m. rehab (RPM) stated R148 was om 5/18/16, through 5/23/16. was assessed as being when ambulating all longer ave assist of one. On 5/23/16, o changed, and needed or all mobility (including	F	157			

Facility ID: 00271

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		AND HUMAN SERVICES				FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING _			08/;	31/2016
NAME OF !	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	3			527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	5/22/16, R148 had were expected to n neuro's, which they notification would b time a call is warrar change in cognition when medical atten is required. The do had a hematoma w documented in the would be called on! At 2:43 p.m. the dir entered and stated be called unless sta bleeding, adding th expect from the sta When interviewed of licensed practical n unsure if R148 had reviewing the notes definitely notify the was unable to locat physician on 5/23/1 hematoma and lace complaints of not fe also stated from rea R148 had a change status the MD shou When interviewed of medical doctor (MD on 5/23/16 at 1:05 a was in the office to was reviewed by he fax identified R148 MD-A denied any k status. "We didn't N	a wound on her head. Staff otify the physician and start did. RN-B stated a fax be acceptable, and the only inted is when there there was a n or a change in neuro's or otion from the emergency room becumentation identified (R148) with some bleeding. This was record and the physician by if the bleeding did not stop. rector of nursing (DON) a physician would not need to aff were unable to stop the is is what the physician would off. on 8/31/16, at 3:22 p.m. nurse (LPN)-A stated he was any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the 6, following the fall with a eration on 5/22/16, and eeling well on 5/23/16. LPN-A ading the progress notes, e in status, with a change in	F 15	57			

If continuation sheet Page 11 of 28

		AND HUMAN SERVICES				FORM	10/04/2016 APPROVED 0938-0391			
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245210	B. WING		08/;	31/2016				
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
LAKE M	INNETONKA SHORES	;			527 SHORELINE DRIVE SPRING PARK, MN 55384					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 157	routine fax to sign of next was a notificat did we see a chang bleeding." MD-A st communication, and decline in status, no but "given her histo Although R148 shor status after her fall 5/23/16, the facility comprehensively as changes and failed possible medical int A facility policy date Change of Conditio indicated staff was time there was a sig also directed staff to record the time call what was reported a policy included a "lis what should be repo- injury requiring first A facility policy date Prevention and Mar review date 2/16, id trauma or unwitnes not able to state if the alert the physician of changes. It also dir into the medical reco- appearance at the to response to event,	orders for therapy, and the ion of her death. "Nowhere je in neuro status or the ated there was a failure in d it appeared R148 had a ot necessarily a head bleed, ry you gotta wonder." wed a change in her medical and subsequent death on had not recognized and ssessed these medical to contact the physician for terventions for R148. ed as reviewed on 2/16, on Physician Notification Policy, to notify the physician any gnificant change in condition. It o document in the medical ed, the person spoken to, and their response if any. The st of possible examples of orted", which identified any aid, and any falls. ed as reviewed 2/16, Fall nagement Program Policy lentified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry cord including patient time of discovery, patient evidence of injury, location, otification, responsible party	F 1	57						

Facility ID: 00271

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SI	<u>38-039</u> JRVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLE	TED
		245210	B. WING _		08/31/	2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) OMPLETIOI DATE
F 241	Continued From pa	age 12	F 24	1		
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 24	1	10)/7/16
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.				
	by: Based on observa review, the facility f	NT is not met as evidenced tion, interview and document ailed to ensure a dignified consistently provided for 1 of 3 riewed for dignity.		Corrective Action: To correct th practice for resident #80, LSW interviewed resident to make su have proper understanding of w	re we hat time	
	Findings include:			the resident would prefer to rise bed. Weekly check-ins with Res Services for this resident will occ	sident cur to	
	7/25/16, identified I required extensive	imum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility,		ensure resident needs are being Corrective Action as it applies to	other	
	During interview on	endent on staff for transfers. 8/29/16, at 4:24 p.m. R80 eel staff treated her with		residents: The policy and proce call light response and dignity w reviewed and are current. All re preferences are assessed upon	ere	
	dignity because it s lag of time," in getti dressing. R80 stat her then, "Leave th so R80 has to, "Lay someone to help fin	eemed, "Like there's always a ing assistance with cares and ed the staff often start helping e room and not come back," y there on the bed waiting for hish dressing me." R80 stated		admission, minimally quarterly a indicated with a change in reque services from family or resident. are trained on timely response of lights and meeting resident requ hire and minimally annually with	est of All staff f call ests upon annual	
	"Rejected and unca			training. An in-service will be pro review the importance of resider preferences and Dignity policy d	nt uring the	
	room with her call I practical nurse (LP turned off R80's ca	a.m. R80 was in bed in her ight turned on. Licensed N)-B entered the room and Il light. LPN-B applied a s and asked her, "Are you		week of October 3, 2016. This t be discussed at resident council upcoming in October as to resid preference and timeliness of ser Household residents will be inte	ent vices.	

Facility ID: 00271

If continuation sheet Page 13 of 28

							0938-039			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	,	SURVEY PLETED			
		245210	B. WING _			08/3	81/2016			
NAME OF	PROVIDER OR SUPPLIEF	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE M	INNETONKA SHORE	S		4527 SHORELINE DRIVE SPRING PARK, MN 55384						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE			
F 241	waiting to get up," would inform the m 7:57 a.m. R80 aga outside the room. turned off the call would be coming, applied a warm wa the room. At 8:25 a.m. R80 r assistance being of ready for the day a stated she was, "V had been waiting f [a.m.]." R80 state help had happene "Lonelier because dining room]." At after observation b room and helped h 9:28 a.m. R80 was the dining room ar with only two other room at a different breakfast alone in When interviewed stated R80 had co helped timely in th residents sometim periods if they are typically, "Really b During interview o stated staff, "Try to	R80 stated she had, "Been to which LPN-B stated she pursing assistant (NA) staff. At in turned on her call light LPN-B entered the room and light and told R80 the NA staff "In a minute." LPN-B then ashcloth to R80's eyes and left emained in bed without any offered to help her get up or as she had requested. R80 Vaiting on my aides [NA]," and or help to get up, "since 7:30 d having to wait this long for d before, and it makes her feel, I have to eat by myself [in the B:29 a.m. (thirty five minutes began) NA-A entered R80's her get dressed for the day. At assisted out of her room to ad seated at a table by herself, residents seated in the dining table. R80 was served the dining room. on 8/31/16, at 9:34 a.m. NA-A mplained about not being e morning before to her, and es have to wait for longer short staffed because they are	F 24	41	LSW to learn preference on what time residents would like to get up and go sleep each day. A committee has be formed to discuss ongoing staffing patterns in the morning/evening and h we can best meet our residents preferences. Reoccurrence will be prevented by: Weekly Audits will be done on 10% or residents to ensure resident s preferences are being met when it co 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 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 QA Team. QA will determine frequen audits c. The Administrator will be response for compliance.	to een how of the omes es o d to t				

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		& MEDICAID SERVICES					0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:		E SURVEY PLETED		
		245210	B. WING			08/3	31/2016		
NAME OF I	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE				
LAKE MI	NNETONKA SHORES	3		4527 SHORELINE DRIVE SPRING PARK, MN 55384					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE		
F 241	Continued From pa	age 14	F 2	241					
	clinical coordinator should not have to be helped with care anyone to wait a lo	on 8/31/16, at 12:20 p.m. LPN (LPN)-C stated residents wait for extended periods to es adding, "We don't ever want ng period of time," because, and they need to feel trust in							
F 282 SS=D	resident should be an environment tha and/or enhanceme life."	licy dated 12/2014, identified cared for, "In a manner and in at promotes maintenance nt of each resident's quality of RVICES BY QUALIFIED ARE PLAN	F 2	282			10/7/16		
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of							
	by: Based on observa review, the facility f interventions to pro residents (R80) rev Findings include:	NT is not met as evidenced tion, interview and document failed to implement care plan prote skin integrity for 1 of 4 viewed for pressure ulcers.			Corrective Action: To correct this for resident 80, upon identification that he were not being floated, it was immedia corrected and staff involved were re-educated on resident plan of care. care plan was reviewed and is current The Team Sheet was updated to mate Care Plan interventions.	ately The t.			
	7/25/16, identified l required extensive	nimum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility, pressure ulcer formation.			Corrective Action as it applies to other residents: The policy and procedure to care plan was reviewed and is current	for			

Facility ID: 00271

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245210 **B** WING 08/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 15 F 282 "Limited physical mobility in bed," and R80 had, and My Best Day/assignment sheet are "Potential for alteration in skin integrity." The care reviewed minimally quarterly and with plan directed staff to, "Keep heels elevated in change in status and updated with any bed." changes. We will audit the team sheets to make sure the current team sheets match During observation of morning care on 8/31/16, at the care plan for each resident. When 8:29 a.m. R80 was laying in her room in bed. there is a change in care the Clinical Nursing assistant (NA)-A pulled back R80's Coordinators (or designee) will update the bedding exposing R80's legs and feet. R80's team sheets and the care plan. There will heels were not being floated with any devices or be an in-service regarding the process of pillows, instead they were directly on the updating of care plan and team sheets for mattress. R80 stated, "My heel hurts," and the all nursing the week of October 3, 2016. back of her heel was reddened in color. There were no visible open areas. At 8:59 a.m. R80 Reoccurrence will be prevented by: was assisted to the bathroom and NA-A stated Weekly Audits will be completed by R80 reddened heel, "Kind of feels soft." Clinical Coordinators. They will chose 10% of the residents each week to make When interviewed on 8/31/16, at 9:34 a.m. NA-A sure care plans match team sheets and stated R80's heels were not being floated when that the services indicated on the plan of she removed her bedding and her right heel was care are being followed. reddened. NA-A stated she had noticed times in the past where R80's heels were not floated when The Correction will be monitored by: a. The audits will be given to the Clinical she would assist her with morning cares. Further, Administrator for review. NA-A stated R80's heels have been red in the morning before when they are not floated, "Their b. Administrator will report audits to the usually red." QA Team. QA will determine frequency of audits During interview on 8/31/16, at 9:52 a.m. licensed c. The Clinical Administrator will be practical nurse (LPN)-B stated the care plan was responsible for compliance. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 10/04/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		245210	B. WING		08/3	31/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE		
LAKE M	INNETONKA SHORES	3		SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	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 28:	2		
F 309 SS=G	483.25 PROVIDE (HIGHEST WELL B Each resident mus	CARE/SERVICES FOR EING t receive and the facility must	F 309	9		10/7/16
	or maintain the high mental, and psycho	ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on interview facility failed to acc significant change is the resident fell, for reviewed for accide harm for R148, afte hematoma, lacerat Findings include: R148's Admission I identified she was a 5/18/16 with diagno disease, hypo tens history of falls. R14 Set dated 5/23/16, anticoagulant medi	NT is not met as evidenced y and document review, the urately assess and monitor a about a resident's status after of 2 residents (R148) ents. This resulted in actual er developing a cranial ion and died. Record sheet (undated) admitted to the facility on bases of end stage renal ion, difficulty walking and a 8's admission Minimum Data identified R148 was on an cation (blood thinner), and had ation in the last 6 days.		Resident #148 expired on 5/23/201 Corrective Action as it applies to oth residents: The policy and procedure assessment and provider notificatio reviewed and is current. All residen assessed upon admission, minimall quarterly and as needed with change condition. All residents with change condition are reviewed with IDT dail physicians updated timely as per cli indications and per policy. The facil EMR also alerts nurses to documen and report of NARs to potential chan status each shift. An in-service for nursing staff will be presented durin week of 10/3/2016 related to recogn and assessment of status change a timely notification of physician/ provi-	er es for n was its are y le of e of y and nical lity ntation nge in g the nition ind	

Facility ID: 00271

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	F OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· /	E SURVEY PLETED	
				A. BUILDING				
		245210	B. WING			08/3	31/2016	
	PROVIDER OR SUPPLIER	6	STREET ADDRESS, CITY, STATE, ZIP COD 4527 SHORELINE DRIVE			Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PRING PARK, MN 55384 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 309	R148's Compreher dated 5/18/16, ider person, place and to consciousness as a status noted weak for falls. R148's Individual F 5/18/16, identified I ambulation with us assist of one for tra It also noted R148 care plan failed to a The Physical Thera 5/18/16, identified r in walking as the tr of care as 5/18/16. for falls and weak month. R148 was weakness, fatigue impacting ability to perform activities o independently. R14 left knee feeling like The facility Therap Maintenance Progr identified under Wa room, A1 [assist of to all destinations." Physical Therapist A Resident Occurre 6:00 p.m. identified	hsive Data Collection form ntified R148 was oriented to time, with level of alert. Further, the neurological ness and a history of and risk Resident Care Plan dated R148 was independent with e of a walker, and required ansfers until seen by therapy. was alert and oriented. The address the risk for falls. apy (PT) Plan of Care dated muscle weakness and difficulty eatment diagnosis, with a start It also noted hospitalization less, with three falls in the past noted to have complaints of and impaired balance ambulate, transfer and of daily living (ADLs) safely and 48 noted significant fatigue and e it would buckle with gait. y to Nursing Functional ram form dated 5/18/16, s "Independent Toilet, Bed to , Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] ' This form was completed by	F3	809	team including information to be re The information presented will revia policy on reporting Change of Cond and Policy on Falls. At this in-servi will review elnteract tools, and the reporting of a Significant Change p note. This will ensure ongoing and consistent monitoring of any chang condition is completed with medica intervention. Reoccurrence will be prevented by a. Audits for significant change will completed in daily IDT meeting. All will be reviewed for significant char Policy will be followed for proper notification of provider, Administrat family. b. 24 hour report will be reviewed of Clinical Coordinators to check for of in condition. The nurse in charge of building will be reviewing on the weekends. The Correction will be given to the Cl Administrator for review. b. Administrator for review. c. The Clinical Administrator will be responsible for ongoing compliance	ew the dition ice staff rogress le in l : be falls nge. or, and daily by change f the y: linical o the ency of		

Facility ID: 00271

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OI	FORM. MB NO.	10/04/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245210	B. WING			08/:	31/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	;			4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	room, knees gave of floor by staff. Medi- voicemail at 6:35 p. A Resident Occurre 9:00 p.m. identified floor, noting a fall w and laceration to th report noted medica including "pressure compress to hemat was notified by fax hours and 10 minut R148 identified she hurt, and was holdin noted after the fall w Review Form dated of the residents pos The picture identified dresser, which was television. Review of the facilit monitoring tool use neurological sympto from 9:00 pm thru 5 no changes in neur 9:00 p.m. thru 5/23/1 R148's right and lef but identified there neuro check even t slow to respond on at 9:00 a.m. and 1:0 fell hitting her head laceration. There w Check Flow sheet a there was no date in	out, and was lowered to the cal provider was notified via	F	309			

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		AND HUMAN SERVICES & MEDICAID SERVICES							FORM	: 10/04/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONS	TRUCTION		0	(X3) DAT	E SURVEY IPLETED
		245210	B. WING	à					08/	31/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY	, STATE, ZIP C	ODE		
LAKE MI	NNETONKA SHORES	i				DRELINE DRI i PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			(EACH CORRE ROSS-REFERE		SHOULD	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 19	F	309)					
	showed no changes reactive to light.	s, and pupils were equal and								
	to the the physician 5/23/16, which was form identified: "6:0 dining room 'my known assistant registered to a sitting position "9:00 pm. Residen herself' and ambula she fell, hitting her head. VS [vital sign checks] are being r after fall was 79/49 135/87" There we to the physician foll was marked, "Note	Transmittal Form was faxed with a faxed date identified as hand written on the form. The 0 p.m. while ambulating to ees gave out'. NAR [nursing I] caught her and lowered her on floor." It also identified: t 'thought she could do it ated to the bathroom where head. There is a bump on s] and neuro's [neurological nonitored. Blood pressure . It was then 106/74 then as no further data on the form owing the ellipsis. This form d" and signed by the physician ed back to the facility on h.								
	was reviewed. The the occurrence, how interventions of res with all transfers, an increased weaknes (international norma for measurement o clotting, was within date or time identifi	Falls Follow Up Form for R148 form lacked date or time of wever identified long term ident changed to assist of one nd therapy notified of s. Neuro at baseline and INR alized ratio), a laboratory test f anticoagulants for blood normal limits. There was no ed of when this form was ong term interventions.								
	Program dated 5/23 status for R148. R1	ng Functional Maintenance 3/16, identified a change in 48 needed assistance of one chair/chair to bed transfers								

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		AND HUMAN SERVICES				FORM	: 10/04/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245210	B. WING _			08/	31/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE M	INNETONKA SHORES	3		-	527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	and sit to stand. A c with assistance of c completed by physi R146's Care Confe 5/23/16, identified: did hit head." It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is r FWW [four wheeled resident in moderat SBA [stand by assis Review of R148's p through 5/24/16, ide - 5/23/16 at 10:03 a "fall noted". - 5/23/16 at 8:23 an identified "Resident mobility, ambulation has had a decline of SBA [stand by assis walker]." - 5/23/16 at 12:47 p thought she could of bathroom where sh Resident landed on head on built in dre with call light close Injury description w Bleeding and bump	change was made to walking one at all times. The form was ical therapy assistant-A. erence Summary dated "[R148] had 2 falls on Sunday, o noted: "Had increase in weekend and increased ummary noted: "Resident was vith all mobility, ambulation, are but has had a decline over now SBA [stand by assist] with d walker]. Balance score puts te risk for falls. Resident is st] for dressing/toileting." orogress notes dated 5/18/16, entified the following: a.m. Fax received from MD, m care conference summary, t was ind [independent] with all n, and self-cares walker but over the weekend and is not st] with FWW [four wheeled o.m. by RN-B "Resident do it herself and ambulated to ne fell in the doorway. n her back after hitting her isser on way down. Put in bed at hand. Close monitor." vas "Hit back/top of head.	F 30	09			

If continuation sheet Page 21 of 28

		AND HUMAN SERVICES			FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING		08/;	31/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE MI	MINNETONKA SHORES SPRING I) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG (EACH CR(C)	527 SHORELINE DRIVE SPRING PARK, MN 55384				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 309	Continued From pa back of head dry, n - 5/23/16 at 6:16 p.r very weak and shak shift, had room tray cont [continue] to m -5/23/16 at 22:26 p. roommate called ou She heard a loud cr entered the room at face down, unrespo- rolled to her back a [respirations] abser DNR/DNI." Review of the facilit dated 5/23/16, at 9: mark on box observ R [right] cheek." Me first aid required, no identified R148 was respond verbally an The physician was p.m. Review of the PT D 5/23/16 identified th 5/23/16: "PTA [phys nursing of pt [patier and shakiness. Du got a w/c [wheelcha very weak after 2nd in speaking." The PT - Therapist	Ige 21 o infection noted." m. by LPN-A "Res [resident] ky today. Stayed in bed all for dinner, appetite poor. Will nonitor." m. by LPN-A "Res [resident] ut for a nurse from the hallway. rash that woke her up. Writer nd found res [resident] lying ponsive. Res [resident] was nd sternal rub tried. Resp nt, pulse absent, res [resident] ty Resident Occurrence Report 45 p.m. identified a check wed on floor and, "bleeding on edical attention required, no; b; witness, no. The form a unconscious, unable to nd "res [resident] had expired." notified on 5/23/16 at 11:00 waily Treatment Notes on ne following: sical therapy assistant] alerted nt] grey coloring, weakness e to pt increased weakness air] for pt." It also noted "Pt d fall. Pt shaky even with voice Progress & Discharge	F 309	DEFICIENCY)		
	Summary dated 5/2	Progress & Discharge 24/16, identified: "Pt [patient] bectedly last night following				

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CENTEI STATEMENT AND PLAN C	RS FOR MEDICARE	AND HUMAN SERVICES AND HUMAN SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245210 TEMENT OF DEFICIENCIES	• •	S		FORM. MB NO. (X3) DATE COM 08/:	10/04/2016 APPROVED 0938-0391 E SURVEY PLETED 31/2016
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 309	decline over the pas "Skilled services pro- included There ex [training and pt [pati- patient's abilities in and ADLs prior to fu pt passing away." When interviewed of program manager (receiving therapy fro- On 5/18/16, R148 v independent, and w distances was to have the resident (R146) assistance of one for transferring and am When interviewed of registered nurse (R 5/22/16, R148 had were expected to no neuro's, which they notification would be time a call is warrar change in cognition when medical atten is required. The do had a hematoma w documented in the would be called only At 2:43 p.m. the dire entered and stated be called unless sta bleeding, adding thi expect from the sta	st few days." It also noted: ovided since start of care therapeutic exercises], gait ent] education which improved Amb [ambulation], transfers unctional decline leading up to on 8/31/16, at 2:09 p.m. rehab (RPM) stated R148 was om 5/18/16, through 5/23/16. was assessed as being when ambulating all longer ave assist of one. On 5/23/16, o changed, and needed or all mobility (including abulation). on 8/31/16, at 2:29 p.m. N)-B stated after the fall on a wound on her head. Staff otify the physician and start did. RN-B stated a fax e acceptable, and the only a voing in neuro's or ation from the emergency room ocumentation identified (R148) ith some bleeding. This was record and the physician y if the bleeding did not stop. ector of nursing (DON) a physician would not need to aff were unable to stop the is is what the physician would	F3	309			

Facility ID: 00271

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245210	B. WING		08/;	31/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE M	INNETONKA SHORES	3		1527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	unsure if R148 had reviewing the notes definitely notify the was unable to locat physician on 5/23/1 hematoma and lace complaints of not fe also stated from rea R148 had a change in status the medica notified. When interviewed of stated a fax was re- a.m. at the office, b receive it at that tim her colleague on 5/ R148 had a bump of knowledge of a cha didn't know that she received from the fa sign orders for ther notification of her d did we see a chang bleeding." MD-A st communication, and decline in status, no but added, "Given h R148 was admitted was independent w bed to chair, sit to s only needed staff a more than 100 feet 5/23/16, following th R148 hit her head. medical status less R148 complained s	age 23 I any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the 16, following the fall with a eration on 5/22/16, and eeling well on 5/23/16. LPN-A ading the progress notes, e in status, and with a change al doctor (MD) should be on 8/31/16, at 4:46 p.m. MD-A ceived on 5/23/16, at 1:05 but nobody was in the office to ne. The fax was reviewed by /23/16. The fax identified on the head. MD-A denied any ange in status and stated, "We e was bleeding." Notification acility included a routine fax to rapy, and the next was a leath. MD-A added, "No where ge in neuro status or the tated there was a failure in d it appeared R148 had a ot necessarily a head bleed, her history you gotta wonder." I to the facility on 5/18/16, and rith; toileting, transferring from stand, walking in her room and ssistance of one, if ambulating that 24 hours after the fall. she was not feeling very well, shaky and needed staff	F 309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245210	B. WING	i		08/3	31/2016
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES				4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	though she was pre R148 also needed a ambulation at all tim assistance of one s feet, and had neuro status 12 hours afte showed a change in fall on 5/22/16, the comprehensively re changes and failed possible medical int actual harm for R14 A facility policy date Change of Conditio indicated staff was time there was a sig also directed staff to record the time callo what was reported a policy included a "lis what should be repo- injury requiring first A facility policy date Prevention and Mar review date 2/16, id trauma or unwitness not able to state if th alert the physician of changes. It also dir into the medical reco appearance at the to response to event, of medical provider no notification, and nur	asfers and toileting even eviously independent with this. additional staff assistance for nes, which was a change from taff for long distances of 100+ logical changes in her pupil er her fall. Although R148 in her medical status after her facility had not recognized and assess these medical to contact the physician for terventions which resulted in 8 who subsequently died. d as reviewed on 2/16, in Physician Notification Policy, to notify the physician any gnificant change in condition. It b document in the medical ed, the person spoken to, and their response if any. The st of possible examples of orted", which identified any aid, and any falls. d as reviewed 2/16, Fall nagement Program Policy entified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry ford including patient ime of discovery, patient evidence of injury, location, otification, responsible party rsing actions.		309			
F 314	483.25(c) TREATM		F	314	4		10/7/16

		AND HUMAN SERVICES				FORM /	10/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY PLETED
		245210	B. WING			08/3	31/2016
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	3			527 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 314 SS=D	Continued From pa PREVENT/HEAL P	-	FS	314			
	resident, the facility who enters the facil does not develop p individual's clinical they were unavoida pressure sores rece	prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that uble; and a resident having eives necessary treatment and e healing, prevent infection and from developing.					
	by: Based on observat review, the facility fa were implemented	NT is not met as evidenced tion, interview and document ailed to ensure interventions to reduce the risk of pressure 1 of 4 residents (R80) are ulcer care.			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.		
	7/25/16, identified F required extensive and was at risk for R80's Skin Risk and 7/20/16, identified F signs and symptom sensation of lower e assessment identifi developing pressure	imum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility, pressure ulcer formation. d Braden assessment, dated R80 to have fragile skin and is of neuropathy with, "Tingling extremity or feet." Further, the ed R80 was at, "Mild Risk" or e ulcers. and was at, "Mild Risk" or			Corrective Action as it applies to other residents: The policy and procedure skin risk and pressure ulcer prevention was reviewed and is current. To prevention reoccurrence for other residents were pull a report of all pressure issues in Click Care and audit the Care Plan to make sure the proper instructions and Team Sheets. An in-service will be here reviewing the Skin at Risk Policy to for floating of heels and points of pressure The Team Sheets will be reviewed to insure all areas of concern are addree All residents are assessed upon admission for skin risk and the care pressure the care provide the team of the service of the	e for ion vent will Point o re on ield iollow ure. o essed.	
	"Limited physical m "Potential for altera	obility in bed," and R80 had, tion in skin integrity." The care o, "Keep heels elevated in			and my best day/ team sheet update interventions. All residents are asses minimally quarterly and with change	ed with essed	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		245210	B. WING		08/31/201	16
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE SPRING PARK, MN 55384		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	(5) LETIC (TE
F 314	bed." R80's most recent l identified R80 had n heels were describe During observation 8:29 a.m. R80 was Nursing assistant (l bedding exposing F heels were not beir pillows, instead the mattress. R80 stat back of her heel wa were no visible ope was assisted to the R80 reddened heel When interviewed of stated R80's heels she removed her be reddened. NA-A stat the past where R80 she would assist he NA-A stated R80's morning before whe usually red." During interview on licensed practical n (LPN)-B stated R80 pressure ulcers" be and incontinence. unaware of any cor heels which would of aware of anything v stated if staff attem refused, it should b	Body Audit dated 8/15/16, no current pressures and her	F 31	 4 status impacting risk and the care and my best day/ team sheet are to reflect interventions or change risk. Reoccurrence will be prevented the Clinical Coordinator or designee the care plan, assessment and te sheets to ensure all of the inform accurate. Staff will audit 10% of residents each week to make sur areas are matching and that the interventions are in place. The Correction will be monitored a. The audits will be given to the Administrator for review. b. The Clinical Administrator will a audits to the QA Team. QA will d frequency of audits. c. The Administrator will be respondent of the respondent of the compliance. 	updated s in skin by: auditing eam ation is the re all by: Clinical report etermine	

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		AND HUMAN SERVICES				FORM	10/04/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245210	B. WING			08/3	31/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	3			1527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa support" they had b previous night or m When interviewed a LPN-B stated R80's floated while she w should have docum weren't. A facility Skin Risk a directive to, "Impl and to provide appr for pressure ulcers, standards of care." general care guidel	ige 27 been floated during the	1	314	DEFICIENCY)		

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		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	-6717074	RINTED: 10/07/2016 FORM APPROVED MB NO: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A _o BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245210	B. WING		09/02/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	ā
LAKE MI	NNETONKA SHORES	i		4527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE COMPLETION
K 000	INITIAL COMMENT	rs	КO	000	
	FIRE SAFETY				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departm Fire Marshal Divisio the time of this surv Building 1, was four compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National f	Survey was conducted by the nent of Public Safety, State on on September 02, 2016. At yey, Lake Minnetonka Shores, nd not in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.			
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Healthcare Fire Ins	R THE FIRE SAFETY -TAGS) TO:		EPOC	
	State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145			
	By email to:				
	r DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
			A: BUILDING 01	1		
		245210	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/0	02/2016
	INNETONKA SHORES	8	452	PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or pr 3. The name and/or responsible for cor- prevent a reoccurror This 3-story buildin Type I (332) constr 1966 with additions partial basement a facility has a fire all detection in corridor corridor that is more department notificat In June of 2011, a constructed and de construction. It con to the existing nurse from an attached a construction has a detection in the con corridors, is fully fir monitored for autor notification. The n kitchen, community	Attate.mn.us and m@state.mn.us RRECTION FOR EACH BT INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. If was determined to be of fuction. Original construction in a in 1974 & 1982. It has a nd is fully fire sprinklered. The arm system with smoke ors and spaces open to the nitored for automatic fire ation. 1-story building was betermined to be of Type II (222) ntains a basement, is attached sing home and is fire separated ussisted living facility. The new fire alarm system with smoke rridors and spaces open to the re sprinkler protected and is matic fire department ew construction contains the y room and chapel. The facility 33 beds and had a census of	K 000			

Facility ID: 00271

If continuation sheet Page 2 of 3

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI		NO. 0938-039 DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		245210	B. WING		09/02/2016
IAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
AKE M	NNETONKA SHORES	3		527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
K 000	Continued From pa	age 2	K 000		
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is enced by:			
K 050 SS=C		FETY CODE STANDARD	K 050		9/6/16
	signal and simulatic conditions. Fire drill times under varying on each shift. The and is aware that d routine. Responsib conducting drills is persons who are q Where drills are co 6:00 AM a coded a instead of audible a 18.7.1.2, 19.7.1.2 This STANDARD Based on docume interview, the facilit documentation tha once per shift per of varying times and of NFPA 101, Section practice could affect Findings include: On a facility tour be and 01:30 PM on S observation reveal provide documentation during the third shi 2016.	tice was confirmed by the hand the time of inspection.		Electronic notifications have been implemented to ensure accurate fire d are conducted once per shift per quar This has been implemented as of 9/6/ Cory Gerber, the Director of Maintena will update computer system in advar and monitor electronic calendar notifications to pre a reoccurrence of this deficiency.	ter. 16. nce nce,

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(<i>'</i>	2) MULTIPLE CONSTRUCTION BUILDING 02 - BLDG TWO		E SURVEY
		245210	B. WING			/02/2016
	PROVIDER OR SUPPLIER		45	STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	ſS	K 000			
	FIRE SAFETY					
THE FACILITY'S POC WILL S ALLEGATION OF COMPLIAN DEPARTMENT'S ACCEPTAN SIGNATURE AT THE BOTTO PAGE OF THE CMS-2567 WI VERIFICATION OF COMPLIA	COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS					
	UPON RECEIPT OF AN ACC	MPLIANCE WITH THE AS BEEN ATTAINED IN				
	Minnesota Departn Fire Marshal Division the time of this sum Building 1, was fou compliance with the in Medicare/Medica 483.70(a), Life Safi edition of National	Survey was conducted by the nent of Public Safety, State on on September 02, 2016. At vey, Lake Minnetonka Shores, nd not in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (M Healthcare Fire Ins	R THE FIRE SAFETY (-TAGS) TO:		EDA	0	
	State Fire Marshal 445 Minnesota St., St. Paul, MN 5510	Division Suite 145		EPU		
	By email to:					

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.

		AND HUMAN SERVICES			-	FORM A	10/06/2016 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 2 - BLDG TWO	(X3) DATE SURVEY COMPLETED	
		245210	B: WING			09/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER	L			REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	5			27 SHORELINE DRIVE PRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
К 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficit 2. The actual, or pr 3. The name and/or responsible for corre prevent a reoccurre This 3-story buildin Type I (332) constr 1966 with additions partial basement at facility has a fire at detection in corridor corridor that is more department notificat In June of 2011, a constructed and de construction. It con to the existing nurs from an attached at detection in the con corridors, is fully fir monitored for autor notification. The new kitchen, community	tate.mn.us and m@state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. If tile of the person rection and monitoring to ence of the deficiency. g was determined to be of uction. Original construction in a in 1974 & 1982. It has a nd is fully fire sprinklered. The arm system with smoke ors and spaces open to the hitored for automatic fire ation. 1-story building was etermined to be of Type II (222) ntains a basement, is attached sing home and is fire separated ussisted living facility. The new fire alarm system with smoke rridors and spaces open to the etermined to be of Type II (222) ntains a basement, is attached is sisted living facility. The new fire alarm system with smoke rridors and spaces open to the the sprinkler protected and is matic fire department ew construction contains the y room and chapel. The facility 33 beds and had a census of	ĸ	000			

Facility ID: 00271

If continuation sheet Page 2 of 3

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	E CONSTRUCTION			
D PLAN O	FCORRECTION	IDENTIFICATION NUMBER.	A, BUILDING 02 - BLDG TWO				
		245210	B. WING 09/				
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
AKE MI	NNETONKA SHORES	3		527 SHORELINE DRIVE SPRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
K 000	Continued From pa	age 2	K 000				
		42 CFR, Subpart 483.70(a) is					
K 050 SS=C		FETY CODE STANDARD	K 050			9/6/16	
	signal and simulati conditions. Fire dril times under varyin on each shift. The and is aware that or routine. Responsib conducting drills is persons who are q Where drills are co 6:00 AM a coded a instead of audible 18.7.1.2, 19.7.1.2 This STANDARD Based on docume interview, the facili documentation tha once per shift per varying times and NFPA 101, Section practice could affe Findings include: On a facility tour b and 01:30 PM on a observation reveal provide document during the third sh 2016. This deficient prace	ne transmission of a fire alarm on of emergency fire Ils are held at unexpected g conditions, at least quarterly staff is familiar with procedures frills are part of established ility for planning and assigned only to competent ualified to exercise leadership. onducted between 9:00 PM and announcement may be used alarms. is not met as evidenced by: entation review and staff ty could not provide it fire drills were conducted quarter for all staff under conditions as required by 2000 n 18.7.1.2. This deficient ct all 114 residents. etween the hours of 09:30 AM September 02, 2016, led that the facility could not ation for conducting a fire drill ift in the second quarter of		Electronic notifications have be implemented to ensure accurate are conducted once per shift per This has been implemented as Cory Gerber, the Director of Ma will update computer system in and monitor electronic calendar notifications a reoccurrence of this deficience	e fire drills er quarter. of 9/6/16. aintenance advance, to prevent		



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Lake Minnetonka Shores September 21, 2016 Page 2

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 Lake Minnetonka Shores September 21, 2016 Page 4

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
			A. BUILDING.			
		00271	B. WING		08/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		PRELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.	10-03-16 <i>GPN</i>			
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnocoto	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
	epartment of Health Y DIRECTOR'S OR PROVIE	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed

6899

09/30/16

STATE FORM

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL	
		00271	B. WING		08/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AKE M	INNETONKA SHORES		RELINE DF PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLET DATE
2 000	Continued From po	ao 1	2 000	DEFICIENCY)		
2 000	Department of Heal you electronically. Jis necessary for State enter the word "corrected prior to electronical prior terviewed these ordet they will be completed Minnesota Departmente State Licensing federal software. Tatassigned to Minness Nursing Homes. The appears in the far lectra field as the far lectra field as evidence by." For are the Suggested I Time period for Corrected prior or correction or correction or correction or correction or correction of the findings which as a evidence by." For are the Suggested I Time period for Corrected for Correction Plan Field The State I Singested I Time period for Correction Singested I Time period for Correction Plan Singested I	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 5, through August 31, 2016, epartment's staff, visited the the following correction Please indicate in your prection that you have ers, and identify the date when ted. the following the date when ted. the following the survey as numbers have been ota state statutes/rules for e assigned tag number eff column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of this column also includes are in violation of the state tement, "This Rule is not met allowing the surveyors findings Method of Correction and trection. RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.		The assigned tag number appear far left column entitled "ID Prefix The state statute/rule number ar corresponding text of the state s out of compliance is listed in the "Summary Statement of Deficier column and replaces the "To Col- portion of the correction order. column also includes the finding are in violation of the state statut statement, "This Rule is not met evidenced by." Following the su- findings are the Suggested Meth Correction and the Time Period IC correction. PLEASE DISREGARD THE HEA THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN CO CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	<pre>(Tag." id the tatute/rule ncies" mply" This gs which e after the as irveyors od of For ADING OF H DF TO Y. THIS TO ION FOR</pre>	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LAKE M	INNETONKA SHORES		ORELINE DRIV PARK, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 2	2 265			
2 265	MN Rule 4658.008 Resident Health St	5 Notification of Chg in atus	2 265			10/7/16
	physicians, physicians, physicians, physicians, physicians, practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the have criteria which appropriate notification. A. an accident	involving the resident which I has the potential for requiring	t			
	B. a significant physical, mental, c example, a deterior	c change in the resident's or psychosocial status, for ration in health, mental, or s in either life-threatening				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision resident from the n	to transfer or discharge the ursing home; or				
	E. expected ar	nd unexpected resident deaths				
	This MN Requirem by:	ent is not met as evidenced				

(EACH DEFICIENCY REGULATORY OR L ontinued From pa ased on interview cility failed to info irtinent informatio cer the resident fe viewed for falls. ndings include: 148's Admission F entified she was a	4527 SHO SPRING P TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING DRESS, CITY, PRELINE DF PARK, MN 5 PREFIX TAG 2 265	STATE, ZIP CODE	(X5) COMPLE DATE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa ased on interview cility failed to info informatio er the resident fe viewed for falls. ndings include: 148's Admission F entified she was a	4527 SHO SPRING P TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 3 and document review, the rm the resident's physician of n about the resident's status	RELINE DF PARK, MN S ID PREFIX TAG	RIVE 55384 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other	COMPLE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa ased on interview cility failed to info rrtinent informatio er the resident fe viewed for falls. ndings include: 148's Admission F entified she was a	ge 3 and document review, the rm the resident's status	PARK, MN S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other	COMPLE
(EACH DEFICIENCY REGULATORY OR L ontinued From pa ased on interview cility failed to info irtinent informatio cer the resident fe viewed for falls. ndings include: 148's Admission F entified she was a	ge 3 and document review, the rm the resident's physician of n about the resident's status	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Resident # 148 expired on 5/23/2016 Corrective Action as it applies to other	COMPLE
ased on interview cility failed to info intinent informatio ter the resident fe viewed for falls. ndings include: 148's Admission F entified she was a	and document review, the rm the resident's physician of n about the resident's status	2 265	Corrective Action as it applies to other	
cility failed to info irtinent informatio er the resident fe viewed for falls. ndings include: 148's Admission F entified she was a	rm the resident's physician of n about the resident's status		Corrective Action as it applies to other	
sease, hypo tensi story of falls. The ata Set identified edication (blood t edication in the la omprehensive Da 18/16, identified F ace and time, with ert. Neurological story of and risk for 148's Individual R 18/16, identified F nbulation with use	ta Collection form dated 148 was oriented to person, 1 level of consciousness as status noted weakness and a or falls. esident Care Plan dated 148 was independent with of a walker, and required		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	f
sist of one for tra also noted R148 re plan failed to a the Physical Thera 18/16, identified r walking as the tra care as 5/18/16. r falls and weakne onth. R148 was n eakness, fatigue a pacting ability to	nsfers until seen by therapy. was alert and oriented. The address the risk for falls. py (PT) Plan of Care dated nuscle weakness and difficulty eatment diagnosis, with a start It also noted hospitalization ess, with three falls in the past noted to have complaints of and impaired balance ambulate, transfer 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 	
	8/16, identified F bulation with use ist of one for tra lso noted R148 e plan failed to a e Physical Thera 8/16, identified n valking as the tre care as 5/18/16. falls and weakne nth. R148 was n akness, fatigue a bacting ability to form activities of	48's Individual Resident Care Plan dated 8/16, identified R148 was independent with bulation with use of a walker, and required sist of one for transfers until seen by therapy. Iso noted R148 was alert and oriented. The e plan failed to address the risk for falls. e Physical Therapy (PT) Plan of Care dated 8/16, identified muscle weakness and difficulty valking as the treatment diagnosis, with a start care as 5/18/16. It also noted hospitalization falls and weakness, with three falls in the past nth. R148 was noted to have complaints of akness, fatigue and impaired balance bacting ability to ambulate, transfer and form activities of daily living (ADLs) safely and ependently. R148 noted significant fatigue and	8/16, identified R148 was independent with bulation with use of a walker, and required sist of one for transfers until seen by therapy. Iso noted R148 was alert and oriented. The e plan failed to address the risk for falls. e Physical Therapy (PT) Plan of Care dated 8/16, identified muscle weakness and difficulty valking as the treatment diagnosis, with a start care as 5/18/16. It also noted hospitalization falls and weakness, with three falls in the past nth. R148 was noted to have complaints of akness, fatigue and impaired balance bacting ability to ambulate, transfer and form activities of daily living (ADLs) safely and	 48's Individual Resident Care Plan dated 8/16, identified R148 was independent with bulation with use of a walker, and required ist of one for transfers until seen by therapy. Iso noted R148 was alert and oriented. The e plan failed to address the risk for falls. e Physical Therapy (PT) Plan of Care dated 8/16, identified muscle weakness and difficulty valking as the treatment diagnosis, with a start care as 5/18/16. It also noted hospitalization falls and weakness, with three falls in the past nth. R148 was noted to have complaints of akness, fatigue and impaired balance bacting ability to ambulate, transfer and form activities of daily living (ADLs) safely and ependently. R148 noted significant fatigue and

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00271	B. WING		08/3	1/2016
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00/3	1/2010
		4527 SHC	DRELINE DR			
	NNETONKA SHORES		PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 265	Continued From pa	age 4	2 265			
	left knee feeling like	e it would buckle with gait.		building will be reviewing on the weekends.	Э	
	Maintenance Progr identified R146 was Chair/Chair to Bed, identified under Wa room, A1 [assist of	y to Nursing Functional cam form dated 5/18/16 s" Independent Toilet, Bed to Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] This form was filled out by A.		The Correction will be monitore a. The audits will be given to the Administrator for review. b. Administrator will report aud QA Team. QA will determine fr audits c. The Clinical Administrator with responsible for ongoing compli	e Clinical its to the equency of Il be	
	6:00 p.m. identified without injury. R148 room, knees gave	ence Report dated 5/22/16, at R146 had a witnessed fall 3 was walking to the dining out, and was lowered to the cal provider was notified via .m. of the fall.				
	9:00 p.m. identified floor, noting a fall w and laceration to th report noted medic including "Pressure compress to hemat was notified by fax fall. R148 identified	ence Report dated 5/22/16, at R148 was observed on the vith injury, including hematoma ie back/top of head. The al attention was required, to stop bleeding" and "Cold toma". The medical provider on 5/23/16 at 1:10 a.m. of the d she hit her head, and her holding her head with one er the fall 79/49.				
	monitoring tool use neurological sympto- from 9:00 pm thru 5 no changes in neur 9:00 p.m. thru 5/23 identified on 5/23/1 R148's right and let	ty Neuro Check Flow sheet (a od to identify changes in om changes), dated 5/22/16 5/23/16 at 1:00 p.m. identified rological status from 5/22/16 at /16 at 5:00 a.m. The sheet 6 at 9:00 a.m. and 1:00 p.m. ft pupils were slow to respond were no changes from last				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AKE MI	NNETONKA SHORES		ORELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265		hough R148's pupils were	2 265			
	at 9:00 a.m. and 1:0 fell hitting her head laceration to the ba was another entry of sheet after the 1:00 no date identified (k identified but just "F	these two separate occasions 00 p.m., 12 hours after R148 resulting in a hematoma and ck/top of R148's head. There on the Neuro Check Flow 0 p.m. notation but there was blank) and no specific time PM". This entry showed no s were equal and reactive to				
ph wi ou he It cc ba is [n pr th fo p	physician faxed on written on the form. while ambulating to out'. NAR [nursing her and lowered he It also identified "9: could do it herself" bathroom where sh is a bump on head. [neurological check pressure after fall w then 135/87" The form to the physicia form was marked "	Transmittal Form sent to the 5/23/16 which was hand The form identified "6:00 p.m. dining room 'my knees gave assistant registered] caught of to a sitting position on floor." 00 pm. Resident 'thought she and ambulated to the the fell, hitting her head. There VS [vital signs] and neuro's (vital signs] an				
	Program dated 5/20 status for R146 and one for toileting, be transfers and sit to	ng Functional Maintenance 3/16, identified a change in d R146 needed assistance of d to chair/chair to bed stand. A change was made to ance of one at all times. The by physical therapy				
	R148's Care Confe	rence Summary dated				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LAKE M	INNETONKA SHORES	5	ORELINE DRI\ PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 265	5/23/16, identified I did hit head". It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is FWW [four wheele resident in modera SBA [stand by assis Review of R148 pro through 5/24/16, id - 5/23/16 at 10:03 a "fall noted". - 5/23/16 at 8:23 ar summary, identified [independent] with self-cares walker b weekend and is no FWW [four wheele - 5/23/16 at 12:47 p thought she could o bathroom where sh Resident landed or head on built in dre with call light close Injury description w Bleeding and bump - 5/23/16 at 4:16 p. back of head dry, n - 5/23/16 at 6:16 p. very weak and sha	R148 "Had 2 falls on Sunday, to noted "Had increase in weekend and increased ummary noted "Resident was with all mobility, ambulation, ker but has had a decline over now SBA [stand by assist] with d walker]. Balance score puts te risk for falls. Resident is st] for dressing/toileting." ogress notes dated 5/18/16, entified the following: a.m. Fax received from MD, m titled care conference d "Resident was ind all mobility, ambulation, and ut has had a decline over the t SBA [stand by assist] with d walker]." o.m. by RN-B "Resident do it herself and ambulated to he fell in the doorway. her back after hitting her esser on way down. Put in bed at hand. Close monitor." was "Hit back/top of head. o as result." m. by LPN-A "Laceration on				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/	31/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
LAKE MI	INNETONKA SHORES					
	1	SPRING	PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	age 7	2 265			
	roommate called of She heard a loud c entered the room a face down, unrespo- rolled to her back a [respirations] abser DNR/DNI." Review of the facili dated 5/23/16, at 9 mark on box with o R [right] cheek." Me first aid required, n identified R148 was respond verbally ar The physician was p.m. Review of the PT E 5/19/16 to 5/23/16 5/23/16: "PTA [physical nursing of pt [patient and shakiness. Du got a w/c [wheelcha very weak after 2nd in speaking." The PT-Therapist F Summary dated 5/2	.m. by LPN-A "Res [resident] ut for a nurse from the hallway. rash that woke her up. Writer ind found res [resident] lying ponsive. Res [resident] was and sternal rub tried. Resp int, pulse absent, res [resident] ty Resident Occurrence Report :45 p.m. identified a check bserved on floor, "bleeding on edical attention required, no; o; witness, no. The form is unconscious, unable to nd "res [resident] had expired." notified on 5/23/16 at 11:00 Daily Treatment Notes from identified the following: sical therapy assistant] alerted nt] grey coloring, weakness ue to pt increased weakness air] for pt." It also noted "Pt d fall. Pt shaky even with voice Progress & Discharge 24/16, identified "Pt [patient] pectedly last night following	t			
	"Skilled services pr included There ex training And pt edu patient's abilities in	st few days." It also noted ovided since start of care [therapeutic exercises], gait cation which improved Amb [ambulation], transfers unctional decline leading up to				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	INNETONKA SHORES		DRELINE DRIV PARK, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 8	2 265			
	program manager receiving therapy fr On 5/18/16, R148 v independent, and v distances was to ha the resident (R148) assistance of one f transferring and an When interviewed or registered nurse (F 5/22/16, R148 had were expected to n	on 8/31/16, at 2:29 p.m. N)-B stated after the fall on a wound on her head. Staff otify the physician and start				
	notification would b time a call is warra change in cognition when medical atter is required. The do had a hematoma w documented in the would be called on At 2:43 p.m. the dir entered and stated be called unless sta	r did. RN-B stated a fax be acceptable, and the only nted is when there there was a n or a change in neuro's or ntion from the emergency room ocumentation identified (R148) with some bleeding. This was record and the physician ly if the bleeding did not stop. rector of nursing (DON) a physician would not need to aff were unable to stop the is is what the physician would aff.				
	licensed practical n unsure if R148 had reviewing the notes definitely notify the was unable to locat physician on 5/23/1 hematoma and lac complaints of not fe	on 8/31/16, at 3:22 p.m. hurse (LPN)-A stated he was l any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the 16, following the fall with a eration on 5/22/16, and beeling well on 5/23/16. LPN-A ading the progress notes,				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
_AKE MI	NNETONKA SHORES		ORELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 265	R148 had a change status the MD shou When interviewed of medical doctor (ME on 5/23/16 at 1:05 at was in the office to was reviewed by he fax identified R148 MD-A denied any k status. "We didn't Notification receive routine fax to sign of next was a notificat did we see a change bleeding." MD-A st communication, an decline in status, no but "given her histo Although R148 sho status after her fall 5/23/16, the facility comprehensively at changes and failed possible medical in A facility policy date Change of Conditio indicated staff was time there was a si also directed staff t record the time call what was reported	e in status, with a change in	, t			
	what should be rep injury requiring first A facility policy date	orted", which identified any				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		00271	B. WING		08/31/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ΔΚΕ ΜΙ	NNETONKA SHORES		ORELINE DR			
	1	SPRING	PARK, MN 5		I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		
2 265	Continued From pa	ge 10	2 265			
	trauma or unwitnes not able to state if t alert the physician changes. It also div into the medical rec appearance at the response to event,	lentified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry cord including patient time of discovery, patient evidence of injury, location, otification, responsible party rsing actions.				
	director of nursing of inservice nursing st is notified timely of condition, then aud TIME PERIOD FOR	THOD OF CORRECTION: The (DON) or designee could (aff on ensuring the physician significant changes in residen it charts to ensure compliance R CORRECTION: Twenty-one	t 			
0 505	(21) days.		0.505			
2 565	Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		10/7/16	
		omprehensive plan of care personnel involved in the 				
	by: Based on observati review, the facility f interventions to pro	ent is not met as evidenced on, interview and document ailed to implement care plan mote skin integrity for 1 of 4 iewed for pressure ulcers.		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.		
	Findings include:					

STATE FORM

KN7Z11

If continuation sheet 11 of 30

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00271	B. WING		08/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	NNETONKA SHORES		RELINE DF PARK, MN 3			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLET DATE
2 565	Continued From pa	age 11	2 565			
	7/25/16, identified F required extensive and was at risk for R80's care plan dat "Limited physical m "Potential for altera plan directed staff t bed." During observation 8:29 a.m. R80 was Nursing assistant (I bedding exposing F heels were not beir pillows, instead the mattress. R80 stat back of her heel wa were no visible ope was assisted to the	assistance with bed mobility, pressure ulcer formation. ted 8/3/16, identified R80 had, nobility in bed," and R80 had, tion in skin integrity." The care to, "Keep heels elevated in of morning care on 8/31/16, at laying in her room in bed. NA)-A pulled back R80's R80's legs and feet. R80's ng floated with any devices or y were directly on the ted, "My heel hurts," and the as reddened in color. There en areas. At 8:59 a.m. R80 a bathroom and NA-A stated l, "Kind of feels soft."		Corrective Action as it applies to residents: The policy and processkin risk and pressure ulcer pre- was reviewed and is current. To reoccurrence for other residents pull a report of all pressure issu- Click Care and audit the Care P make sure the proper instruction Team Sheets. An In-service wir reviewing the Skin at Risk Policy floating of heels and points of put The Team Sheets will be review insure all areas of concern are a All residents are assessed upon admission for skin risk and the of and my best day/ team sheet up interventions. All residents are minimally quarterly and with char status impacting risk and the car and my best day/ team sheet ar to reflect interventions or chang risk.	dure for vention prevent s we will es in Point lan to ns are on Il be held y to follow ressure. ed to addressed. care plan odated with assessed inge of re plan e updated es in skin	
	When interviewed of stated R80's heels she removed her by reddened. NA-A st the past where R80 she would assist he NA-A stated R80's morning before who usually red." During interview on practical nurse (LP used as an, "Overa that person," and st	on 8/31/16, at 9:34 a.m. NA-A were not being floated when edding and her right heel was rated she had noticed times in 0's heels were not floated when er with morning cares. Further, heels have been red in the en they are not floated, "Their a 8/31/16, at 9:52 a.m. licensed N)-B stated the care plan was Ill guide on how to take care of taff were to, "Follow the care posed to be followed."		 Reoccurrence will be prevented Clinical Coordinator or designee the care plan, assessment and sheets to ensure all of the inforr accurate. Staff will audit 10% o residents each week to make su areas are matching and that the interventions are in place. The Correction will be monitored a. The audits will be given to the Administrator for review. b. The Clinical Administrator will audits to the QA Team. QA will frequency of audits. c. The Administrator will be resp 	auditing team nation is f the ure all d by: c Clinical report determine	

KN7Z11

If continuation sheet 12 of 30

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (>	(3) DATE SURVEY COMPLETED	
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		DRELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
2 565	Continued From pa	age 12	2 565			
	LPN-C stated R80's floated while she w	on 8/31/16, at 1:56 p.m. s heels should have been as in bed, or the nursing staff nented the reason why they		compliance		
	4/2016, identified a "Ensure the resider required to maintain	Policy and Procedure dated care plan was used to, nt has the appropriate care n or attain the resident's cticable function possible."				
	director of nursing inservice staff abou	THOD OF CORRECTION: The (DON) or designee could ut implementing the care plan es to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		10/7/16	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00271	B. WING		08/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
	INNETONKA SHORES		RELINE DF			
		SPRING P	ARK, MN 5	55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	by: Based on interview facility failed to acc significant change a the resident fell, for reviewed for accide harm for R148, afte hematoma, lacerati Findings include: R148's Admission F identified she was a 5/18/16 with diagno disease, hypo tensi history of falls. R14 Set dated 5/23/16, anticoagulant medi received the medic R148's Comprehen dated 5/18/16, iden person, place and t consciousness as a status noted weakr for falls. R148's Individual R 5/18/16, identified F ambulation with use assist of one for tra It also noted R148 care plan failed to a The Physical Thera 5/18/16, identified r in walking as the tra	Record sheet (undated) admitted to the facility on oses of end stage renal ion, difficulty walking and a 8's admission Minimum Data identified R148 was on an cation (blood thinner), and had ation in the last 6 days. nsive Data Collection form tified R148 was oriented to		Resident # 148 expired on 5/23/2 Corrective Action as it applies to residents: The policy and proced assessment and provider notifica reviewed and is current. All resid assessed upon admission, minin quarterly and as needed with char condition. All residents with char condition are reviewed with IDT of physicians updated timely as per indications and per policy. The file EMR also alerts nurses to docum and report of NARs to potential of status each shift. An In-service finursing staff will be presented du week of 10/3/2016 related to reco and assessment of status chang timely notification of physician/ pri team including information to be The information presented will re policy on reporting Change of Co and Policy on Falls. At this in-se will review eInteract tools, and th reporting of a Significant Change note. This will ensure ongoing al consistent monitoring of any cha condition is completed with medi intervention. Reoccurrence will be prevented find a. Audits for significant change w completed in daily IDT meeting. J will be reviewed for significant change w completed in daily IDT meeting. J will be reviewed for significant change w completed in daily IDT meeting. J will be reviewed for significant change w completed in daily IDT meeting. J will be reviewed for significant change w completed in daily IDT meeting. J	other ures for tition was dents are hally inge of daily and clinical acility nentation hange in or rring the ognition e and rovider reported. view the indition rvice staff e progress and nge in cal by: rill be All falls ange.	

FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
	00271	B. WING		08/3	1/2016
R OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NKA SHORES	5				
ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLET DATE
nued From pa ls and weakn h. R148 was ness, fatigue ting ability to m activities o endently. R14 hee feeling like acility Therapy enance Progr ied R148 was Chair to Bed, ied under Wa A1 [assist of destinations." cal Therapist hident Occurre h.m. identified ut injury. R148 knees gave by staff. Medi nail at 6:35 p hident Occurre h.m. identified noting a fall w ceration to the noted medic ing "pressure ress to hema otified by fax and 10 minu	age 14 ess, with three falls in the past noted to have complaints of and impaired balance ambulate, transfer and f daily living (ADLs) safely and the noted significant fatigue and e it would buckle with gait. y to Nursing Functional am form dated 5/18/16, s "Independent Toilet, Bed to , Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] This form was completed by (PT)-A. ence Report dated 5/22/16, at I R148 had a witnessed fall 8 was walking to the dining out, and was lowered to the ical provider was notified via .m. of the fall. ence Report dated 5/22/16, at I R148 was observed on the with injury, including hematoma the back/top of head. The al attention was required, to stop bleeding" and "cold toma." The medical provider on 5/23/16, at 1:10 a.m., 4 tes after the injury from the fall.	2 830	DEFICIENCY) b. 24 hour report will be rev Clinical Coordinators to che in condition. The nurse in cl building will be reviewing or weekends. The Correction will be moni a. The audits will be given t Administrator for review. b. Administrator for review. b. Administrator will report a QA Team. QA will determin audits c. The Clinical Administrato	iewed daily by eck for change harge of the tored by: o the Clinical audits to the e frequency of r will be	
	R OR SUPPLIER DNKA SHORES SUMMARY STA ACH DEFICIENC: GULATORY OR L ACH DEFICIENC: ACH DEFICIENC: A	RECTION IDENTIFICATION NUMBER: 00271 R OR SUPPLIER STREET AD WKA SHORES 4527 SHC SPRING F SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) nued From page 14 Is and weakness, with three falls in the past n. R148 was noted to have complaints of ness, fatigue and impaired balance ting ability to ambulate, transfer and m activities of daily living (ADLs) safely and endently. R148 noted significant fatigue and thee feeling like it would buckle with gait. acility Therapy to Nursing Functional enance Program form dated 5/18/16, fied R148 was "Independent Toilet, Bed to (Chair to Bed, Sit to Stand." The form also fied under Walking, "Independent walking in A1 [assist of 1] longer distances [100+ feet] destinations." This form was completed by cal Therapist (PT)-A. ident Occurrence Report dated 5/22/16, at o.m. identified R148 had a witnessed fall ut injury. R148 was walking to the dining knees gave out, and was lowered to the by staff. Medical provider was notified via nail at 6:35 p.m. of the fall. ident Occurrence Report dated 5/22/16, at o.m. identified R148 was observed on the noting a fall with injury, including hematoma the roted medical attention was required, ing "pressure to stop bleeding" and "cold ress to hematoma." The medical provider otified by fax on 5/23/16, at 1:10 a.m., 4 and 10 minutes after the injury from the fall.	FICIENCIES RECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING O0271 B. WING R OR SUPPLIER STREET ADDRESS, CITY, 4527 SHORELINE DR SPRING PARK, MN 5 SUMMARY STATEMENT OF DEFICIENCIES GACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG nued From page 14 2 830 Is and weakness, with three falls in the past 1. R148 was noted to have complaints of ness, fatigue and impaired balance ting ability to ambulate, transfer and m activities of daily living (ADLs) safely and endently. R148 noted significant fatigue and here feeling like it would buckle with gait. acility Therapy to Nursing Functional enance Program form dated 5/18/16, fied R148 was "Independent Toilet, Bed to (Chair to Bed, Sit to Stand." The form also fied under Walking, "Independent walking in A1 [assist of 1] longer distances [100+ feet] destinations." This form was completed by cal Therapist (PT)-A. wident Occurrence Report dated 5/22/16, at 0.m. identified R148 was walking to the dining knees gave out, and was lowered to the sy staff. Medical provider was notified via nail at 6:35 p.m. of the fall. wident Occurrence Report dated 5/22/16, at 0.m. identified R148 was observed on the noting a fall with injury, including hematoma acceration to the back/top of head. The noted medical attention was required, ing "pressure to stop bleeding" and "cold ress to hematoma." The medical provider otified by fax on 5/23/16, at 1:10 a.m., 4 and 10 minutes after the injury from the fall.	FICIENCIES RECTION (X1) PROVIDER/SUPPLIER/CLA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 00271 B. WING a. BUNG B. WING 00271 B. WING R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) nued From page 14 2 830 b. 24 hour report will be rev Clinical Coordinators to che in condition. The nurse in ci building will be reviewing or weekends. Is and weakness, with three falls in the past the addity to ambulate, transfer and mactivities of daily living (ADLS) safely and enednetly. F148 noted significant faigue and mactivities of daily living (ADLS) safely and enednetly. R148 was "Independent Toilet, Bed to Chair to Bed, Sit to Stand." The form also ited under Walking, "Independent toilet, Bed to Chair to Bed, Sit to Stand." The form also ited under Walking, "Independent toilet, Bed to Chair to Bed, Sit to Stand." The form also ited under Walking to the dining knees gave out, and was lowered to the noting a fall with injury, including hematoma ceration to the back/top of head. The motod a fall with injury, including hematoma cerast to hematoma." The medical provider otified by fax on 5/23/16, at 1:10 a.m., 4 and 10 minutes after the injury from the fall.	FIGENCIES (M) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP 00271 B. WING 08/3 R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NKA SHORES SPRING PARK, MN 55384 SUMMARY STATEMENT OF DEFICIENCIES: SPRING PARK, MN 55384 PROVIDERP PLAN OF CORRECTION INFORMATION SUMMARY STATEMENT OF DEFICIENCIES: SUMMARY STATEMENT OF DEFICIENCIES: SIMMARY STATEMENT OF DEFICIENCIES: SPRING PARK, MN 55384 PROVIDERP PLAN OF CORRECTION INFORMATION SUMMARY STATEMENT OF DEFICIENCIES: SUMMARY STATEMENT OF DEFICIENCIES: STREET ADDRESS, CITY, STATE, ZIP CODE PROVIDERP PLAN OF CORRECTION INFORMATION SUMMARY STATEMENT OF DEFICIENCIES: SUMMARY STATEMENT OF DEFICIENCIES: NEACH OPACING STATEMENT OF INFORMATION IPREFIX PROVIDERP PLAN OF CORRECTION INFORMATION PROVIDERP PLAN OF CORRECTION INFORMATION SUMMARY STATEMENT OF DEFICIENCY: PROVIDERS PLAN OF CORRECTION INFORMATION PREFIX PROVIDERS SUMMARY STATEMENT OF DEFICIENCY: IPREFIX PROVIDERS PLAN OF CORRECTION INFORMATION PREFIX SUMMARY STATEMENT OF DEFICIENCY: IPREFIX PROVIDERS PLAN OF CORRECTION INFORMATION IPREFIX SUMMARY STATEMENT OF DEFICIENCY: IPREFIX IPREFIX IPREFIX SIGNET THE STATE PLAN OF CORRECTIVE ADDRESS CITY, STATE, IPREFIX IPREFIX

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	NNETONKA SHORES	4527 SHO	ORELINE DRIV	/E		
	NNETONKA SHORES	SPRING	PARK, MN 55	384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 15	2 830			
	dresser, which was television.	next to the residents				
	neurological sympto from 9:00 pm thru & no changes in neur 9:00 p.m. thru 5/23 identified on 5/23/1 R148's right and let but identified there neuro check even t slow to respond on at 9:00 a.m. and 1: fell hitting her head laceration. There w Check Flow sheet a there was no date i specific time identif showed no change reactive to light. A Facility Facsimile to the the physician	d to identify changes in om changes), dated 5/22/16 5/23/16 at 1:00 p.m. identified fological status from 5/22/16 at /16 at 5:00 a.m. The sheet 6, at 9:00 a.m. and 1:00 p.m. ft pupils were slow to respond were no changes from last hough R148's pupils were these two separate occasions 00 p.m., 12 hours after R148 resulting in a hematoma and vas another entry on the Neuro after the 1:00 p.m. notation but dentified (blank) and no ied but just "PM". This entry s, and pupils were equal and				
	form identified: "6:0 dining room 'my kn assistant registered to a sitting position "9:00 pm. Residen herself' and ambula	hand written on the form. The 00 p.m. while ambulating to ees gave out'. NAR [nursing d] caught her and lowered her on floor." It also identified: t 'thought she could do it ated to the bathroom where head. There is a bump on				
	head. VS [vital sign checks] are being r after fall was 79/49 135/87" There w to the physician foll	is] and neuro's [neurological nonitored. Blood pressure . It was then 106/74 then as no further data on the form owing the ellipsis. This form d" and signed by the physician				

STATEMEN	ta Department of He T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			COM	PLETED
		00271	B. WING		08/31/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	•	
AKE MI	NNETONKA SHORES		DRELINE DRIV PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa 5/23/16, at 8:29 a.r An undated facility	-	2 830			
	was reviewed. The the occurrence, ho interventions of res with all transfers, a increased weaknes (international norm for measurement o clotting, was within date or time identifi	e form lacked date or time of wever identified long term sident changed to assist of one nd therapy notified of ss. Neuro at baseline and INR alized ratio), a laboratory test of anticoagulants for blood normal limits. There was no ied of when this form was ong term interventions.				
	Program dated 5/2 status for R148. R for toileting, bed to and sit to stand. A c with assistance of c	ng Functional Maintenance 3/16, identified a change in 148 needed assistance of one chair/chair to bed transfers change was made to walking one at all times. The form was ical therapy assistant-A.				
	5/23/16, identified: did hit head." It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is FWW [four wheele resident in modera	erence Summary dated "[R148] had 2 falls on Sunday, so noted: "Had increase in weekend and increased ummary noted: "Resident was vith all mobility, ambulation, ker but has had a decline over now SBA [stand by assist] with d walker]. Balance score puts te risk for falls. Resident is st] for dressing/toileting."				
	through 5/24/16, id	progress notes dated 5/18/16, entified the following:				
	"fall noted".	a.m. Fax received from MD,				
nesota De TE FORM	epartment of Health		6899 K	N7Z11	If continuati	on sheet 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
_AKE MI	NNETONKA SHORES		ORELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	identified "Resident mobility, ambulation has had a decline of SBA [stand by assist walker]."	n care conference summary, t was ind [independent] with all n, and self-cares walker but over the weekend and is not st] with FWW [four wheeled				
	thought she could bathroom where sh Resident landed or head on built in dre with call light close	b.m. by RN-B "Resident do it herself and ambulated to he fell in the doorway. In her back after hitting her esser on way down. Put in bed at hand. Close monitor." vas "Hit back/top of head. b as result."				
	- 5/23/16 at 4:16 p. back of head dry, n	m. by LPN-A "Laceration on to infection noted."				
	very weak and sha	m. by LPN-A "Res [resident] ky today. Stayed in bed all / for dinner, appetite poor. Will nonitor."				
	roommate called of She heard a loud c entered the room a face down, unrespo rolled to her back a	.m. by LPN-A "Res [resident] ut for a nurse from the hallway. rash that woke her up. Writer and found res [resident] lying ponsive. Res [resident] was and sternal rub tried. Resp nt, pulse absent, res [resident]				
	dated 5/23/16, at 9 mark on box obser R [right] cheek." Me first aid required, no	ty Resident Occurrence Report :45 p.m. identified a check ved on floor and, "bleeding on edical attention required, no; o; witness, no. The form s unconscious, unable to	t			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		ORELINE DRIV PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
		nd "res [resident] had expired." notified on 5/23/16 at 11:00				
	Review of the PT E 5/23/16 identified the second se	Daily Treatment Notes on he following:				
	nursing of pt [patien and shakiness. Du got a w/c [wheelcha	sical therapy assistant] alerted nt] grey coloring, weakness ue to pt increased weakness air] for pt." It also noted "Pt d fall. Pt shaky even with voice	9			
	Summary dated 5/2 passed away unex decline over the pa "Skilled services pr included There ex training and pt [pat patient's abilities in	Progress & Discharge 24/16, identified: "Pt [patient] pectedly last night following ist few days." It also noted: rovided since start of care [therapeutic exercises], gait ient] education which improved Amb [ambulation], transfers unctional decline leading up to				
	program manager receiving therapy fr On 5/18/16, R148 v independent, and v distances was to have the resident (R146)	on 8/31/16, at 2:09 p.m. rehab (RPM) stated R148 was rom 5/18/16, through 5/23/16. was assessed as being when ambulating all longer ave assist of one. On 5/23/16,) changed, and needed for all mobility (including nbulation).				
	registered nurse (F 5/22/16, R148 had were expected to n	on 8/31/16, at 2:29 p.m. RN)-B stated after the fall on a wound on her head. Staff notify the physician and start y did. RN-B stated a fax				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	INNETONKA SHORES	4527 SHO		/E		
		SPRING	PARK, MN 55	384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 19	2 830			
	change in cognition when medical atter is required. The do had a hematoma w documented in the would be called on! At 2:43 p.m. the dir entered and stated be called unless sta bleeding, adding th expect from the sta When interviewed of licensed practical n unsure if R148 had reviewing the notes definitely notify the was unable to locat	on 8/31/16, at 3:22 p.m. urse (LPN)-A stated he was any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the				
	hematoma and lace complaints of not fe also stated from rea R148 had a change	6, following the fall with a eration on 5/22/16, and eeling well on 5/23/16. LPN-A ading the progress notes, e in status, and with a change al doctor (MD) should be				
	stated a fax was re a.m. at the office, b receive it at that tim her colleague on 5/ R148 had a bump of knowledge of a cha	on 8/31/16, at 4:46 p.m. MD-A ceived on 5/23/16, at 1:05 out nobody was in the office to ne. The fax was reviewed by 23/16. The fax identified on the head. MD-A denied any ange in status and stated, "We				
	received from the fa sign orders for ther notification of her d	e was bleeding." Notification acility included a routine fax to apy, and the next was a eath. MD-A added, "No where ge in neuro status or the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00271	B. WING		08/	08/31/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
AKE M	NNETONKA SHORES						
		SPRING I	PARK, MN 55	384			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 20	2 830				
	communication, and decline in status, no but added, "Given h R148 was admitted was independent w bed to chair, sit to s only needed staff as more than 100 feet 5/23/16, following th R148 hit her head. medical status less R148 complained s was gray in color, s assistance with trar though she was pre R148 also needed a ambulation at all tin assistance of one s feet, and had neuro status 12 hours afte showed a change in fall on 5/22/16, the	ated there was a failure in d it appeared R148 had a bt necessarily a head bleed, her history you gotta wonder." to the facility on 5/18/16, and ith; toileting, transferring from stand, walking in her room and ssistance of one, if ambulating . R148 sustained 2 falls, on he fall on 5/23/16 at 9:00 p.m. R148 had changes in her than 24 hours after the fall. he was not feeling very well, haky and needed staff hesfers and toileting even eviously independent with this. additional staff assistance for nes, which was a change from taff for long distances of 100+ blogical changes in her pupil er her fall. Although R148 in her medical status after her facility had not recognized and					
	changes and failed possible medical in	eassess these medical to contact the physician for terventions which resulted in 48 who subsequently died.					
	Change of Conditio indicated staff was time there was a sig also directed staff to record the time call what was reported policy included a "lis	ed as reviewed on 2/16, n Physician Notification Policy, to notify the physician any gnificant change in condition. It o document in the medical ed, the person spoken to, and their response if any. The st of possible examples of orted", which identified any aid, and any falls.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00271	B. WING		08/	08/31/2016	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
AKE MI	NNETONKA SHORES		ORELINE DRIV PARK, MN 553				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 21	2 830				
	Prevention and Ma review date 2/16, ic trauma or unwitnes not able to state if t alert the physician of changes. It also div into the medical red appearance at the response to event,	ed as reviewed 2/16, Fall nagement Program Policy lentified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry cord including patient time of discovery, patient evidence of injury, location, otification, responsible party rsing actions.					
	director of nursing of inservice nursing st consistent monitori	THOD OF CORRECTION: The (DON) or designee could aff to ensuring ongoing and ng of any changes in condition medical intervention, then ure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			10/7/16	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	00/01/2010	
	NNETONKA SHORES	4527 SHC	ORELINE DF			
	NNETONKA SHORE	SPRING F	PARK, MN 5	55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 900	Continued From pa	age 22	2 900			
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review, the facility f were implemented	ent is not met as evidenced ion, interview and document ailed to ensure interventions to reduce the risk of pressure 1 of 4 residents (R80) ure ulcer care.		To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected staff involved were re-educated on resident plan of care.		
	7/25/16, identified l required extensive and was at risk for	nimum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility, pressure ulcer formation.		The care plan was reviewed and is current. The Team Sheet was update match Care Plan interventions. Corrective Action as it applies to othe residents: The policy and procedure care plan was reviewed and is curren	r for t. All	
	7/20/16, identified I signs and symptom sensation of lower	d Braden assessment, dated R80 to have fragile skin and as of neuropathy with, "Tingling extremity or feet." Further, the ied R80 was at, "Mild Risk" or re ulcers.		residents are assessed on admission care plan initiated. All residents care and My Best day/ assignment sheet a reviewed minimally quarterly and with change in status and updated with ar changes. To prevent reoccurrence for other residents we will audit the team	plan ire iy	
	"Limited physical m "Potential for altera plan directed staff bed."	ted 8/3/16, identified R80 had, nobility in bed," and R80 had, ition in skin integrity." The care to, "Keep heels elevated in		sheets to make sure the current team sheets match the care plan for each resident. When there is a change in c the clinical coordinators (or designee) update the team sheets and the care There will be an in-service regarding	are will plan. the	
	identified R80 had	ost recent Body Audit dated 8/15/16, d R80 had no current pressures and her ere described as, "Clear."		process of updating of care plan and sheets for all nursing the week of Oct 3, 2016.		
	During observation	of morning care on 8/31/16, at		Reoccurrence will be prevented by:		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00271	B. WING		08/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
AKE M	INNETONKA SHORES		DRELINE DF PARK, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 23	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."		h	 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. 		
	licensed practical n (LPN)-B stated R80 pressure ulcers" be and incontinence. unaware of any cor heels which would o aware of anything v stated if staff attem refused, it should b LPN-B stated there support" they had b previous night or m When interviewed a LPN-B stated R80's floated while she w should have docum	ring interview on 8/31/16, at 12:20 p.m. ensed practical nurse clinical coordinator PN)-B stated R80 was at, "Slight risk for essure ulcers" because of her impaired mobility d incontinence. LPN-B stated she was aware of any concerns for R80 concerning her els which would cause them to be red, [I'm] not are of anything wrong with her heels." LPN-B ted if staff attempted to float her heels and she used, it should be documented however, N-B stated there was, "No documentation to oport" they had been floated during the evious night or morning. nen interviewed again on 8/31/16, at 1:56 p.m. N-B stated R80's heels should have been ated while she was in bed, or the nursing staff ould have documented the reason why they ren't.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00271		B. WING		08/	31/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
LAKE MI	INNETONKA SHORES		ORELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 24	2 900			
	a directive to, "Impl and to provide appr for pressure ulcers/ standards of care." general care guidel included, "Elevate h	Policy dated 8/2016, identified ement preventative measures; ropriate treatment modalities /injuries according to industry Further, the policy provided ines for staff to follow which neels off bed as indicated"				
	director of nursing (inservice staff about to prevent pressure audit cares to ensu	(DON) or designee could it implementing the care plan a ulcer development, and then				
	(21) days.	A CORRECTION. Twenty-one				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			9/30/16
	residents shall, at a are legal rights for stay at the facility o treatment and main that these are desc written statement o responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga	tion about rights. Patients and admission, be told that there their protection during their r throughout their course of ntenance in the community and ribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written to describe the right of a d or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide I services for patients in is. Reasonable				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00271	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		RELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21800	accommodations s communication imp speak a language of facility policies, insp local health authori the written stateme to patients, residen chosen representat to the administrator person, consistent	age 25 hall be made for those with pairments and those who other than English. Current pection findings of state and ties, and further explanation of ont of rights shall be available ts, their guardians or their tives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to	21800			
	by: Based on interview facility failed to prov Medicare Non-Cov (R93) reviewed for Findings include: R93's progress not would be completing to assisted living or further recommend R93's medical reco	e dated 7/13/16, identified R93 ng therapy and discharge back n 7/15/16. R93 had, "No lations for continued therapy." ord was reviewed. There was		Resident 93 was discharged prior adequate notice given related to fa and resident's wishes to discharge than anticipated end date of thera Corrective Action as it applies to o residents: The policy and procedu Medicare Denials was reviewed a current. To prevent reoccurrence residents the criteria for denial for Medicare benefits is reviewed dail meetings. This in-service for this o be held the week of 9/26/2016. S training and tool kits were created	amily e earlier py. other ure for nd is for other y at IDT group will pecific	
	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			Reoccurrence will be prevented by will be done weekly by the Reside Services Director (LSW) or design audits will be reviewed monthly to for criteria of discharge to make s notices are given timely.	y: Audits nt nee. The check	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00271	B. WING		08/31/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AKE MI	NNETONKA SHORES		ORELINE DF PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21800		day, 7/16/16, however the	21800	Correction will be monitored by: a. The audits will be given to th	e	
	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."			Administrator for review. b. Administrator will report aud QA Team. QA will determine free audits c. The Administrator will be res for compliance.	ts to the quency of	
	The director of nurs inservice staff about	THOD OF CORRECTION: sing (DON) or designee could it providing Medicare notices nely, and then audit to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			10/7/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by:	ent is not met as evidenced				
	review, the facility f	ion, interview and document ailed to ensure a dignified consistently provided for 1 of 3 riewed for dignity.		To correct the deficient practice to resident #80 LSW interviewed re make sure we have proper unde of what time the resident would p rise and go to bed. Weekly chec	sident to rstanding prefer to	
	Findings include:	nclude: Irterly Minimum Data Set (MDS) dated		resident services for this resident occur to ensure resident needs a met ongoing.	ident will	

STATE FORM

KN7Z11

If continuation sheet 27 of 30

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00271	B. WING		08/31/	2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
_AKE MI	INNETONKA SHORES		DRELINE DF PARK, MN 5			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLE DATE
21805	Continued From pa	ige 27	21805			
21003	7/25/16, identified F required extensive and was totally dep During interview on stated she did not f dignity because it s lag of time," in getti dressing. R80 state her then, "Leave the so R80 has to, "Lay someone to help fir this happens, "All th "Rejected and unca On 8/31/16, at 7:54 room with her call lip practical nurse (LPI turned off R80's cal cream to R80's legs ready to get up?" F waiting to get up?" F waiting to get up?" F waiting to get up," t would inform the nu 7:57 a.m. R80 agai outside the room. I turned off the call lip would be coming, " applied a warm was the room. At 8:25 a.m. R80 re assistance being of ready for the day as stated she was, "W had been waiting fo [a.m.]." R80 stated	R80 had intact cognition, assistance with bed mobility, endent on staff for transfers. 8/29/16, at 4:24 p.m. R80 eel staff treated her with eemed, "Like there's always a ng assistance with cares and ed the staff often start helping e room and not come back," / there on the bed waiting for hish dressing me." R80 stated he time," and it makes her feel, ared for." • a.m. R80 was in bed in her tight turned on. Licensed N)-B entered the room and Il light. LPN-B applied a s and asked her, "Are you R80 stated she had, "Been o which LPN-B stated she ursing assistant (NA) staff. At n turned on her call light LPN-B entered the room and ght and told R80 the NA staff In a minute." LPN-B then shcloth to R80's eyes and left		Corrective Action as it applies to residents: The policy and proced call light response and dignity we reviewed and are current. All resp preferences are assessed upon admission, minimally quarterly ar indicated with a change in request services from family or resident. are trained on timely response of lights and meeting resident request hire and minimally annually with a training. We will do an in-service review the importance of resident preferences and Dignity policy du week of October 3, 2016. This to be discussed at resident council in October as to resident preferent timeliness of services. Househol residents will be interviewed by L learn preference on what time the residents would like to get up and sleep each day. A Committee has formed to discuss on going staffin patterns in the morning/evening a we can best meet our residents preferences. Reoccurrence will be prevented to Weekly audits will be done on 10 residents to ensure resident s preferences are being met when to preferred wake times and the to they are going to bed. Residents preferred wake times will be adde NAR team sheets. Audits of time	dure for re- sident ad as st of All staff call ests upon annual e to t uring the opic will upcoming nce and d SW to e d go to as been ng and how Dy: % of the it comes times ed to ely	
	"Lonelier because I dining room]." At 8	before, and it makes her feel, have to eat by myself [in the :29 a.m. (thirty five minutes egan) NA-A entered R80's		response rates will also be condu ensure ongoing needs are being timely.		

KN7Z11

If continuation sheet 28 of 30

	ta Department of He	ealth (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:		:		LETED
		00271	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		DRELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 28	21805			
	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.			 The Correction will be monitor a. The audits will be given to Administrator for review. b. Administrator will report a QA Team. QA will determine for audits c. The Administrator will be refored for compliance. 	the udits to the requency of	
	clinical coordinator should not have to be helped with care anyone to wait a lo	on 8/31/16, at 12:20 p.m. LPN (LPN)-C stated residents wait for extended periods to es adding, "We don't ever want ng period of time," because, and they need to feel trust in				
	resident should be an environment that	licy dated 12/2014, identified cared for, "In a manner and in at promotes maintenance ent of each resident's quality of				
	The director of nurse staff about ensuring	THOD OF CORRECTION: sing (DON) could inservice g cares are initiated and r each resident, then complete nsure compliance.				
nesota D	TIME PERIOD FO	R CORRECTION: Twenty-one				
ATE FOR	-		6899	KN7Z11	If continuatio	n sheet 29 c

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/	31/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AKE MI	NNETONKA SHORES	S	ORELINE DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 29	21805			
	(21) days.					

Minneso	Minnesota Department of Health						
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		00271	B. WING		08/3	1/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LAKE MINNETONKA SHORES			RELINE DR PARK, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh	nether a violation has been					
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	compliance with all e rule provided at the tag ale number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item aring the initial inspection was					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.					
Minneeste	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to		
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

Electronically Signed

If continuation sheet 1 of 30

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL	
		00271	B. WING		08/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AKE M	INNETONKA SHORES		RELINE DF PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLET DATE
2 000	Continued From po	ao 1	2 000	DEFICIENCY)		
2 000	Department of Heal you electronically. Jis necessary for State enter the word "corrected prior to electronical prior terviewed these ordet they will be completed Minnesota Departmente State Licensing federal software. Tatassigned to Minness Nursing Homes. The appears in the far lectra field as the far lectra field as evidence by." For are the Suggested I Time period for Corrected prior or correction or correction or correction or correction or correction of the findings which as a sevidence by." For are the Suggested I Time period for Correction Field Tag. The state Suggested I Time period for Correction Statute after the statas as evidence by." For are the Suggested I Time period for Correction Field Tag. The State I Suggested I Time period for Correction Field THIS WILL APPEA THERE IS NO RECCION FIELD THIS WILL APPEA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 5, through August 31, 2016, epartment's staff, visited the the following correction Please indicate in your prection that you have ers, and identify the date when ted. the following the date when ted. the following the survey as numbers have been ota state statutes/rules for e assigned tag number eff column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of this column also includes are in violation of the state tement, "This Rule is not met allowing the surveyors findings Method of Correction and trection. RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.		The assigned tag number appear far left column entitled "ID Prefix The state statute/rule number ar corresponding text of the state s out of compliance is listed in the "Summary Statement of Deficier column and replaces the "To Col- portion of the correction order. column also includes the finding are in violation of the state statut statement, "This Rule is not met evidenced by." Following the su- findings are the Suggested Meth Correction and the Time Period IC correction. PLEASE DISREGARD THE HEA THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN CO CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	<pre>(Tag." id the tatute/rule ncies" mply" This gs which e after the as irveyors od of For ADING OF H DF TO Y. THIS TO ION FOR</pre>	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/	31/2016
	PROVIDER OR SUPPLIER	4527 SH	DDRESS, CITY, ST ORELINE DRIV PARK, MN 553	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	ge 2	2 265			
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			10/7/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica A. an accident results in injury and	involving the resident which has the potential for requiring	t			
	physical, mental, o example, a deterior psychosocial status conditions or clinica	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the n	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths				
	This MN Requireme	ent is not met as evidenced				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00271	B. WING		08/31/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	NNETONKA SHORES	S	DRELINE DF PARK, MN 4		
	SUMMARY STA		-	PROVIDER'S PLAN OF CORRECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 265	Continued From pa	age 3	2 265		
	Based on interview and document review, the facility failed to inform the resident's physician of			Resident # 148 expired on 5/23/2016	
		on about the resident's status		Corrective Action as it applies to other	
		ell for 1 of 2 residents (R148)		residents: The policy and procedures	
	reviewed for falls.	· · · · · ·		assessment and provider notification v	was
	Findings include:			reviewed and is current. All residents assessed upon admission, minimally	
	D140's Admission [Depart about (undeted)		quarterly and as needed with change of	
		Record sheet (undated) admitted to the facility on		condition. All residents with change or condition are reviewed with IDT daily a	
		oses of end stage renal		physicians updated timely as per clinic	
		ion, difficulty walking and a		indications and per policy. The facility	
		5/23/16 admission Minimum		EMR also alerts nurses to documenta	
		R148 was on an anticoagulant		and report of NARs to potential chang	e in
		hinner), and had received the		status each shift. An In-service for	
	medication in the la			nursing staff will be presented during t week of 10/3/2016 related to recognition	on
		ta Collection form dated		and assessment of status change and	
		R148 was oriented to person,		timely notification of physician/ provide	
		h level of consciousness as status noted weakness and a		team including information to be repor The information presented will review	
	history of and risk f			policy on reporting Change of Condition	
	notory of and noter			and Policy on Falls. At this in-service	
	R148's Individual R	Resident Care Plan dated		will review eInteract tools, and the	
		R148 was independent with		reporting of a Significant Change prog	ress
		e of a walker, and required		note. This will ensure ongoing and	
		Insfers until seen by therapy.		consistent monitoring of any change in	ו
		was alert and oriented. The address the risk for falls.		condition is completed with medical intervention.	
		apy (PT) Plan of Care dated		Reoccurrence will be prevented by:	
		nuscle weakness and difficulty		a. Audits for significant change will be	
		eatment diagnosis, with a start		completed in daily IDT meeting. All fal	
		It also noted hospitalization ess, with three falls in the past		will be reviewed for significant change Policy will be followed for proper	•
		noted to have complaints of		notification of provider, Administrator,	and
		and impaired balance		family.	
		ambulate, transfer and		b. 24 hour report will be reviewed daily	/ by
	perform activities o	f daily living (ADLs) safely and		Clinical Coordinators to check for chai	nge
	independently. R14	8 noted significant fatigue and		in condition. The nurse in charge of th	е

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00271	B. WING		08/3	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	NNETONKA SHORES	4527 SHC	RELINE DF	RIVE		
	NNETONKA SHORES	SPRING F	PARK, MN 5	55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
2 265	Continued From pa	age 4	2 265			
	left knee feeling like	e it would buckle with gait.		building will be reviewing on weekends.	the	
MicCicrotor PA6wroffiv A9flareircwfahh Fmmnfrn9icF	Maintenance Progr identified R146 was Chair/Chair to Bed, identified under Wa room, A1 [assist of	y to Nursing Functional ram form dated 5/18/16 s" Independent Toilet, Bed to , Sit to Stand." The form also alking, "Independent walking in 1] longer distances [100+ feet] This form was filled out by A.		The Correction will be monit a. The audits will be given to Administrator for review. b. Administrator will report a QA Team. QA will determine audits c. The Clinical Administrator responsible for ongoing com	o the Clinical udits to the e frequency of will be	
	6:00 p.m. identified without injury. R148 room, knees gave	ence Report dated 5/22/16, at I R146 had a witnessed fall 8 was walking to the dining out, and was lowered to the ical provider was notified via .m. of the fall.				
	9:00 p.m. identified floor, noting a fall w and laceration to the report noted medic including "Pressure compress to hemat was notified by fax fall. R148 identified	ence Report dated 5/22/16, at I R148 was observed on the with injury, including hematoma is back/top of head. The al attention was required, to stop bleeding" and "Cold toma". The medical provider on 5/23/16 at 1:10 a.m. of the d she hit her head, and her is holding her head with one er the fall 79/49.				
	monitoring tool use neurological sympt from 9:00 pm thru 9 no changes in neur 9:00 p.m. thru 5/23 identified on 5/23/1 R148's right and let	ty Neuro Check Flow sheet (a ed to identify changes in om changes), dated 5/22/16 5/23/16 at 1:00 p.m. identified rological status from 5/22/16 at /16 at 5:00 a.m. The sheet 6 at 9:00 a.m. and 1:00 p.m. ft pupils were slow to respond were no changes from last				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AKE MI	NNETONKA SHORES		ORELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 5	2 265			
	slow to respond on at 9:00 a.m. and 1: fell hitting her head laceration to the ba was another entry of sheet after the 1:00 no date identified (k identified but just "F	though R148's pupils were these two separate occasions 00 p.m., 12 hours after R148 I resulting in a hematoma and ack/top of R148's head. There on the Neuro Check Flow 0 p.m. notation but there was blank) and no specific time PM". This entry showed no is were equal and reactive to				
 	physician faxed on written on the form, while ambulating to out'. NAR [nursing her and lowered he It also identified "9: could do it herself" bathroom where sh is a bump on head. [neurological check pressure after fall w then 135/87" The form to the physicia form was marked "	e Transmittal Form sent to the 5/23/16 which was hand . The form identified "6:00 p.m o dining room 'my knees gave assistant registered] caught er to a sitting position on floor." 00 pm. Resident 'thought she and ambulated to the he fell, hitting her head. There . VS [vital signs] and neuro's (s) are being monitored. Blood was 79/49. It was then 106/74 ere was no further data on the an following the ellipsis. This noted" and signed by the 16, and faxed back to the at 8:29 a.m.				
	Program dated 5/2 status for R146 and one for toileting, be transfers and sit to walking with assista	ng Functional Maintenance 3/16, identified a change in d R146 needed assistance of ed to chair/chair to bed stand. A change was made to ance of one at all times. The by physical therapy				
	B148's Care Confe	erence Summary dated				

STATEME	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LAKE M	INNETONKA SHORES		ORELINE DRI\ PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 265	5/23/16, identified I did hit head". It als weakness over the shakiness." The su ind [independent] w and self-cares walk the weekend as is FWW [four wheele resident in modera SBA [stand by assi Review of R148 pro through 5/24/16, id - 5/23/16 at 10:03 a "fall noted". - 5/23/16 at 8:23 ar summary, identified [independent] with self-cares walker b weekend and is no FWW [four wheele - 5/23/16 at 12:47 p thought she could o bathroom where sh Resident landed or head on built in dre with call light close Injury description w Bleeding and bump - 5/23/16 at 4:16 p. back of head dry, r - 5/23/16 at 6:16 p. very weak and sha	R148 "Had 2 falls on Sunday, o noted "Had increase in weekend and increased ummary noted "Resident was with all mobility, ambulation, ser but has had a decline over now SBA [stand by assist] with d walker]. Balance score puts te risk for falls. Resident is st] for dressing/toileting." ogress notes dated 5/18/16, entified the following: a.m. Fax received from MD, n titled care conference d "Resident was ind all mobility, ambulation, and ut has had a decline over the t SBA [stand by assist] with d walker]." o.m. by RN-B "Resident do it herself and ambulated to be fell in the doorway. n her back after hitting her asser on way down. Put in bed at hand. Close monitor." was "Hit back/top of head. o as result." m. by LPN-A "Laceration on				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	Š	ORELINE DRIV PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 7	2 265		,	
	roommate called of She heard a loud c entered the room a face down, unrespo- rolled to her back a [respirations] abser DNR/DNI." Review of the facilit dated 5/23/16, at 9 mark on box with o R [right] cheek." Me first aid required, no identified R148 was respond verbally ar The physician was p.m. Review of the PT D 5/19/16 to 5/23/16 i 5/23/16: "PTA [phys	.m. by LPN-A "Res [resident] ut for a nurse from the hallway rash that woke her up. Writer and found res [resident] lying ponsive. Res [resident] was and sternal rub tried. Resp nt, pulse absent, res [resident] ty Resident Occurrence Repor :45 p.m. identified a check bserved on floor, "bleeding on edical attention required, no; o; witness, no. The form s unconscious, unable to nd "res [resident] had expired." notified on 5/23/16 at 11:00 Daily Treatment Notes from identified the following: sical therapy assistant] alerted nt] grey coloring, weakness				
	and shakiness. Du got a w/c [wheelcha	air] for pt." It also noted "Pt d fall. Pt shaky even with voice				
	Summary dated 5/2 passed away unexp decline over the pa "Skilled services pr included There ex [training And pt educ	Progress & Discharge 24/16, identified "Pt [patient] pectedly last night following st few days." It also noted ovided since start of care [therapeutic exercises], gait cation which improved Amb [ambulation], transfers				
		unctional decline leading up to				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	INNETONKA SHORES		DRELINE DRIV PARK, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 8	2 265			
	program manager receiving therapy fr On 5/18/16, R148 v independent, and v distances was to ha the resident (R148) assistance of one f transferring and an When interviewed or registered nurse (F 5/22/16, R148 had were expected to n	on 8/31/16, at 2:29 p.m. N)-B stated after the fall on a wound on her head. Staff otify the physician and start				
	notification would b time a call is warra change in cognition when medical atter is required. The do had a hematoma w documented in the would be called on At 2:43 p.m. the dir entered and stated be called unless sta	r did. RN-B stated a fax be acceptable, and the only nted is when there there was a n or a change in neuro's or ntion from the emergency room ocumentation identified (R148) with some bleeding. This was record and the physician ly if the bleeding did not stop. rector of nursing (DON) a physician would not need to aff were unable to stop the is is what the physician would aff.				
	licensed practical n unsure if R148 had reviewing the notes definitely notify the was unable to locat physician on 5/23/1 hematoma and lac complaints of not fe	on 8/31/16, at 3:22 p.m. hurse (LPN)-A stated he was l any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the 16, following the fall with a eration on 5/22/16, and beeling well on 5/23/16. LPN-A ading the progress notes,				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AKE MI	NNETONKA SHORES					
(X4) ID	SUMMARY STA		PARK, MN 55	PROVIDER'S PLAN OF	COBRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 9	2 265			
	R148 had a change in status, with a change in status the MD should be notified.					
	medical doctor (ME on 5/23/16 at 1:05 a was in the office to was reviewed by he fax identified R148 MD-A denied any k status. "We didn't Notification receive routine fax to sign of next was a notificat did we see a chang bleeding." MD-A st communication, an decline in status, no but "given her histor	on 8/31/16, at 4:46 p.m. D)-A stated a fax was received a.m. at the office, but nobody receive it at that time. The fax er colleague on 5/23/16. The had a bump on the head. nowledge of a change in know that she was bleeding." d from the facility included a orders for therapy, and the tion of her death. "Nowhere ge in neuro status or the tated there was a failure in d it appeared R148 had a ot necessarily a head bleed, my you gotta wonder."				
	status after her fall 5/23/16, the facility comprehensively a changes and failed	wed a change in her medical and subsequent death on had not recognized and ssessed these medical to contact the physician for terventions for R148.				
	Change of Conditic indicated staff was time there was a si- also directed staff t record the time call what was reported policy included a "li	ed as reviewed on 2/16, on Physician Notification Policy to notify the physician any gnificant change in condition. I o document in the medical led, the person spoken to, and their response if any. The st of possible examples of orted", which identified any a aid, and any falls.	t			
		ed as reviewed 2/16, Fall nagement Program Policy				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00271	B. WING		08/31/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
AKE MI	NNETONKA SHORES		ORELINE DR		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 265	Continued From pa	age 10	2 265		
	trauma or unwitnes not able to state if t alert the physician changes. It also di into the medical rec appearance at the response to event,	dentified with minor head sed fall where the resident is they hit their head, staff was to or nurse practitioner with any rected staff to make an entry cord including patient time of discovery, patient evidence of injury, location, otification, responsible party rsing actions.			
	director of nursing inservice nursing st is notified timely of condition, then aud	THOD OF CORRECTION: The (DON) or designee could taff on ensuring the physician significant changes in resident it charts to ensure compliance			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		10/7/16
		omprehensive plan of care I personnel involved in the t.			
	by: Based on observat review, the facility f interventions to pro	ent is not met as evidenced ion, interview and document ailed to implement care plan mote skin integrity for 1 of 4 riewed for pressure ulcers.		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.	
	Findings include:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00271	B. WING		08/3	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	INNETONKA SHORES		RELINE DF PARK, MN &			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORREC		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLET DATE
2 565	Continued From pa	age 11	2 565			
	7/25/16, identified F required extensive and was at risk for R80's care plan dat "Limited physical m "Potential for altera plan directed staff t bed." During observation 8:29 a.m. R80 was Nursing assistant (f bedding exposing F heels were not beir pillows, instead the mattress. R80 stat back of her heel wa were no visible ope was assisted to the	nimum Data Set (MDS) dated R80 had intact cognition, assistance with bed mobility, pressure ulcer formation. ted 8/3/16, identified R80 had, nobility in bed," and R80 had, tion in skin integrity." The care to, "Keep heels elevated in of morning care on 8/31/16, at laying in her room in bed. NA)-A pulled back R80's R80's legs and feet. R80's ng floated with any devices or by were directly on the ted, "My heel hurts," and the as reddened in color. There en areas. At 8:59 a.m. R80 a bathroom and NA-A stated I, "Kind of feels soft."		Corrective Action as it applies to residents: The policy and process skin risk and pressure ulcer previews was reviewed and is current. To reoccurrence for other residents pull a report of all pressure issue Click Care and audit the Care PI make sure the proper instruction Team Sheets. An In-service wil reviewing the Skin at Risk Policy floating of heels and points of pro The Team Sheets will be reviewed insure all areas of concern are a All residents are assessed upon admission for skin risk and the c and my best day/ team sheet up interventions. All residents are a minimally quarterly and with char status impacting risk and the car and my best day/ team sheet are to reflect interventions or change risk.	dure for vention prevent we will es in Point an to is are on I be held to follow essure. ed to ddressed. are plan dated with assessed nge of re plan e updated es in skin	
	When interviewed of stated R80's heels she removed her b reddened. NA-A st the past where R80 she would assist he NA-A stated R80's morning before who usually red." During interview on practical nurse (LP used as an, "Overa that person," and s	on 8/31/16, at 9:34 a.m. NA-A were not being floated when edding and her right heel was tated she had noticed times in D's heels were not floated when er with morning cares. Further, heels have been red in the en they are not floated, "Their N-B stated the care plan was all guide on how to take care of taff were to, "Follow the care oposed to be followed."		 Reoccurrence will be prevented Clinical Coordinator or designee the care plan, assessment and t sheets to ensure all of the inform accurate. Staff will audit 10% of residents each week to make su areas are matching and that the interventions are in place. The Correction will be monitored a. The audits will be given to the Administrator for review. b. The Clinical Administrator will audits to the QA Team. QA will of frequency of audits. c. The Administrator will be responsed 	auditing eam nation is the re all I by: Clinical report determine	

ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/3	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		DRELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLET DATE
2 565	Continued From pa	age 12	2 565			
	LPN-C stated R80's floated while she w	on 8/31/16, at 1:56 p.m. s heels should have been as in bed, or the nursing staff nented the reason why they		compliance		
	4/2016, identified a "Ensure the resider required to maintain	Policy and Procedure dated care plan was used to, nt has the appropriate care n or attain the resident's cticable function possible."				
	director of nursing inservice staff abou	THOD OF CORRECTION: The (DON) or designee could ut implementing the care plan as to ensure compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			10/7/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00271	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		RELINE DF ARK, MN 5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	by: Based on interview facility failed to acc significant change is the resident fell, for reviewed for accide harm for R148, afte hematoma, lacerat Findings include: R148's Admission I identified she was a 5/18/16 with diagno disease, hypo tens history of falls. R14 Set dated 5/23/16, anticoagulant medic R148's Compreher dated 5/18/16, iden person, place and t consciousness as a status noted weak for falls. R148's Individual F 5/18/16, identified F ambulation with us assist of one for tra It also noted R148 care plan failed to a	Record sheet (undated) admitted to the facility on oses of end stage renal ion, difficulty walking and a 8's admission Minimum Data identified R148 was on an cation (blood thinner), and had ation in the last 6 days. The sive Data Collection form stified R148 was oriented to time, with level of alert. Further, the neurological ness and a history of and risk Resident Care Plan dated R148 was independent with e of a walker, and required unsfers until seen by therapy. was alert and oriented. The address the risk for falls.		Resident # 148 expired on 5/23 Corrective Action as it applies to residents: The policy and proce assessment and provider notific reviewed and is current. All resi assessed upon admission, mini- quarterly and as needed with ch condition. All residents with cha condition are reviewed with IDT physicians updated timely as pe- indications and per policy. The EMR also alerts nurses to docu and report of NARs to potential status each shift. An In-service nursing staff will be presented of week of 10/3/2016 related to re and assessment of status chan timely notification of physician/ team including information to be The information presented will n policy on reporting Change of C and Policy on Falls. At this in-s will review eInteract tools, and t reporting of a Significant Change note. This will ensure ongoing consistent monitoring of any ch condition is completed with med- intervention. Reoccurrence will be prevented a. Audits for significant change completed in daily IDT meeting	o other dures for cation was idents are mally hange of ange of daily and er clinical facility mentation change in for luring the cognition ge and provider e reported. eview the condition ervice staff he le progress and ange in dical	
	5/18/16, identified r in walking as the tr	apy (PT) Plan of Care dated muscle weakness and difficulty eatment diagnosis, with a start It also noted hospitalization		will be reviewed for significant of Policy will be followed for prope notification of provider, Adminis family.	r	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00271	B. WING		08/3	08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
AKE MI	NNETONKA SHORES		DRELINE DF PARK, MN 🕴				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLE DATE	
2 830	Continued From pa	ige 14	2 830				
	month. R148 was weakness, fatigue a impacting ability to perform activities o independently. R14 left knee feeling like The facility Therapy Maintenance Progr identified R148 was Chair/Chair to Bed, identified under Wa room, A1 [assist of to all destinations." Physical Therapist			 b. 24 hour report will be reclinical Coordinators to chin condition. The nurse in building will be reviewing of weekends. The Correction will be montaneous and the audits will be given Administrator for review. b. Administrator for review. b. Administrator will report QA Team. QA will determ audits c. The Clinical Administrator contains and the second se	neck for change charge of the on the nitored by: to the Clinical t audits to the ine frequency of tor will be		
	6:00 p.m. identified without injury. R148 room, knees gave of floor by staff. Medi voicemail at 6:35 p A Resident Occurre 9:00 p.m. identified	ence Report dated 5/22/16, at R148 had a witnessed fall B was walking to the dining but, and was lowered to the cal provider was notified via .m. of the fall. ence Report dated 5/22/16, at R148 was observed on the <i>i</i> th injury, including hematoma					
	and laceration to the report noted medic including "pressure compress to hemat was notified by fax hours and 10 minut R148 identified she hurt, and was holdi noted after the fall Review Form dated of the residents post	e back/top of head. The al attention was required, to stop bleeding" and "cold toma." The medical provider on 5/23/16, at 1:10 a.m., 4 tes after the injury from the fall. hit her head, and her head ng her head with one hand. BP was 79/49. The Fall Huddle d 5/22/16 identified a drawing sition in relation to other items. ed R148's head was touching a					

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
LAKE MI	NNETONKA SHORE					
		SPRING	PARK, MN 55		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	dresser, which was next to the residents television.					
	neurological sympt from 9:00 pm thru 4 no changes in neur 9:00 p.m. thru 5/23 identified on 5/23/1 R148's right and le but identified there neuro check even t slow to respond on at 9:00 a.m. and 1: fell hitting her head laceration. There w Check Flow sheet a there was no date i specific time identifi showed no change reactive to light.	ed to identify changes in om changes), dated 5/22/16 5/23/16 at 1:00 p.m. identified rological status from 5/22/16 at /16 at 5:00 a.m. The sheet 6, at 9:00 a.m. and 1:00 p.m. ft pupils were slow to respond were no changes from last though R148's pupils were these two separate occasions 00 p.m., 12 hours after R148 I resulting in a hematoma and vas another entry on the Neuro after the 1:00 p.m. notation but identified (blank) and no fied but just "PM". This entry is, and pupils were equal and				
	to the the physiciar 5/23/16, which was form identified: "6:0 dining room 'my kn assistant registered to a sitting position "9:00 pm. Residen herself' and ambula she fell, hitting her head. VS [vital sign checks] are being r	e Transmittal Form was faxed n with a faxed date identified as a hand written on the form. The 00 p.m. while ambulating to ees gave out'. NAR [nursing d] caught her and lowered her on floor." It also identified: nt 'thought she could do it ated to the bathroom where head. There is a bump on ns] and neuro's [neurological monitored. Blood pressure 1. It was then 106/74 then				
	to the physician fol was marked, "Note	as no further data on the form lowing the ellipsis. This form ed" and signed by the physician ked back to the facility on				

TATEMENT OF DI ND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00271	B. WING		08/31/2016		
AME OF PROVIDI	ER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
AKE MINNET	ONKA SHORES		ORELINE DRIV PARK, MN 553				
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830 Conti	nued From pa	age 16	2 830				
5/23/	16, at 8:29 a.r	n.					
was in the o interv with a incre (inter for m clottin date	reviewed. The ccurrence, ho ventions of res all transfers, a ased weaknes national norm easurement o ng, was within or time identifi	Falls Follow Up Form for R148 e form lacked date or time of wever identified long term ident changed to assist of one nd therapy notified of as. Neuro at baseline and INR alized ratio), a laboratory test of anticoagulants for blood normal limits. There was no ied of when this form was ong term interventions.					
Progr statu for to and s with a	ram dated 5/2 s for R148. R1 ileting, bed to sit to stand. A c assistance of c	ng Functional Maintenance 3/16, identified a change in 148 needed assistance of one chair/chair to bed transfers change was made to walking one at all times. The form was ical therapy assistant-A.					
5/23/ did h weak shaki ind [ii and s the w FWW resid	16, identified: it head." It als ness over the iness." The sundependent] w self-cares walk reekend as is / [four wheele ent in modera	erence Summary dated "[R148] had 2 falls on Sunday, to noted: "Had increase in weekend and increased ummary noted: "Resident was vith all mobility, ambulation, ker but has had a decline over now SBA [stand by assist] with d walker]. Balance score puts te risk for falls. Resident is st] for dressing/toileting."					
		progress notes dated 5/18/16, entified the following:					
	3/16 at 10:03 a noted".	a.m. Fax received from MD,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/	31/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LAKE MI	NNETONKA SHORES	5	DRELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 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]."					
	thought she could bathroom where sh Resident landed or head on built in dre with call light close	b.m. by RN-B "Resident do it herself and ambulated to he fell in the doorway. In her back after hitting her esser on way down. Put in bed at hand. Close monitor." vas "Hit back/top of head. D as result."				
	- 5/23/16 at 4:16 p. back of head dry, r	m. by LPN-A "Laceration on to infection noted."				
	very weak and sha	m. by LPN-A "Res [resident] ky today. Stayed in bed all / for dinner, appetite poor. Will nonitor."				
	roommate called of She heard a loud c entered the room a face down, unrespo rolled to her back a	a.m. by LPN-A "Res [resident] ut for a nurse from the hallway. grash that woke her up. Writer and found res [resident] lying ponsive. Res [resident] was and sternal rub tried. Resp nt, pulse absent, res [resident]				
	dated 5/23/16, at 9 mark on box obser R [right] cheek." Me first aid required, n	ty Resident Occurrence Report :45 p.m. identified a check ved on floor and, "bleeding on edical attention required, no; o; witness, no. The form s unconscious, unable to				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
_AKE MI	NNETONKA SHORES		ORELINE DRIV PARK, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
		nd "res [resident] had expired." notified on 5/23/16 at 11:00				
	Review of the PT E 5/23/16 identified the second se	Daily Treatment Notes on he following:				
	nursing of pt [patien and shakiness. Du got a w/c [wheelcha	sical therapy assistant] alerted nt] grey coloring, weakness ue to pt increased weakness air] for pt." It also noted "Pt d fall. Pt shaky even with voice	3			
	Summary dated 5/2 passed away unex decline over the pa "Skilled services pr included There ex training and pt [pat patient's abilities in	Progress & Discharge 24/16, identified: "Pt [patient] pectedly last night following ist few days." It also noted: rovided since start of care [therapeutic exercises], gait ient] education which improved Amb [ambulation], transfers unctional decline leading up to				
	program manager receiving therapy fr On 5/18/16, R148 v independent, and v distances was to have the resident (R146)	on 8/31/16, at 2:09 p.m. rehab (RPM) stated R148 was rom 5/18/16, through 5/23/16. was assessed as being when ambulating all longer ave assist of one. On 5/23/16,) changed, and needed for all mobility (including nbulation).				
	registered nurse (F 5/22/16, R148 had were expected to n	on 8/31/16, at 2:29 p.m. RN)-B stated after the fall on a wound on her head. Staff notify the physician and start y did. RN-B stated a fax				

STATE FORM

KN7Z11

If continuation sheet 19 of 30

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	INNETONKA SHORES	4527 SHO		/E		
		SPRING	PARK, MN 55	384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 19	2 830			
	change in cognition when medical atter is required. The do had a hematoma w documented in the would be called on! At 2:43 p.m. the dir entered and stated be called unless sta bleeding, adding th expect from the sta When interviewed of licensed practical n unsure if R148 had reviewing the notes definitely notify the was unable to locat	on 8/31/16, at 3:22 p.m. urse (LPN)-A stated he was any change in status. After s, LPN-A stated he would physician. However, LPN-A te any notification made to the				
	hematoma and lace complaints of not fe also stated from rea R148 had a change	6, following the fall with a eration on 5/22/16, and eeling well on 5/23/16. LPN-A ading the progress notes, e in status, and with a change al doctor (MD) should be				
	stated a fax was re a.m. at the office, b receive it at that tim her colleague on 5/ R148 had a bump of knowledge of a cha	on 8/31/16, at 4:46 p.m. MD-A ceived on 5/23/16, at 1:05 out nobody was in the office to ne. The fax was reviewed by 23/16. The fax identified on the head. MD-A denied any ange in status and stated, "We				
	received from the fa sign orders for ther notification of her d	e was bleeding." Notification acility included a routine fax to apy, and the next was a eath. MD-A added, "No where ge in neuro status or the				

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	INNETONKA SHORES		PRELINE DRIN PARK, MN 55			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	bleeding." MD-A st communication, and decline in status, no but added, "Given h R148 was admitted was independent w bed to chair, sit to s only needed staff as more than 100 feet. 5/23/16, following th R148 hit her head. medical status less R148 complained s was gray in color, s assistance with trar though she was pre R148 also needed a ambulation at all tim assistance of one s feet, and had neuro status 12 hours after showed a change in fall on 5/22/16, the comprehensively re changes and failed possible medical int actual harm for R14 A facility policy date Change of Conditio indicated staff was time there was a sig also directed staff to record the time call what was reported a policy included a "lis	ated there was a failure in d it appeared R148 had a bt necessarily a head bleed, her history you gotta wonder." to the facility on 5/18/16, and ith; toileting, transferring from tand, walking in her room and ssistance of one, if ambulating . R148 sustained 2 falls, on he fall on 5/23/16 at 9:00 p.m. R148 had changes in her than 24 hours after the fall. he was not feeling very well, haky and needed staff heres and toileting even eviously independent with this. additional staff assistance for hes, which was a change from taff for long distances of 100+ logical changes in her pupil er her fall. Although R148 in her medical status after her facility had not recognized and bassess these medical to contact the physician for terventions which resulted in 8 who subsequently died. d as reviewed on 2/16, in Physician Notification Policy, to notify the physician any gnificant change in condition. It is document in the medical ed, the person spoken to, and their response if any. The st of possible examples of ported", which identified any	2 830			

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/	31/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
_AKE MI	NNETONKA SHORES	.	ORELINE DRIV PARK, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Prevention and Ma review date 2/16, ic trauma or unwitnes not able to state if t alert the physician of changes. It also div into the medical red appearance at the response to event,	ed as reviewed 2/16, Fall nagement Program Policy dentified with minor head sed fall where the resident is hey hit their head, staff was to or nurse practitioner with any rected staff to make an entry cord including patient time of discovery, patient evidence of injury, location, otification, responsible party	2 830			
	director of nursing of inservice nursing st consistent monitoria are completed with audit charts to ensu	THOD OF CORRECTION: The (DON) or designee could taff to ensuring ongoing and ng of any changes in conditior medical intervention, then ure compliance. R CORRECTION: Twenty-one	1			
2 900	Ulcers Subp. 3. Pressure comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure s	5 Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical	2 900 r			10/7/16

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		00271	B. WING		08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
_AKE MI	NNETONKA SHORES		DRELINE DF PARK, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 900	Continued From pa	ge 22	2 900			
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility fa were implemented	ent is not met as evidenced on, interview and document ailed to ensure interventions to reduce the risk of pressure 1 of 4 residents (R80) ure ulcer care.		To correct this for resident 80, upon identification that heels were not being floated, it was immediately corrected an staff involved were re-educated on resident plan of care.	d	
		imum Data Set (MDS) dated		The care plan was reviewed and is current. The Team Sheet was updated t match Care Plan interventions.	0	
	required extensive and was at risk for	assistance with bed mobility, pressure ulcer formation.		Corrective Action as it applies to other residents: The policy and procedure for care plan was reviewed and is current.	All	
	7/20/16, identified F signs and symptom sensation of lower e	d Braden assessment, dated R80 to have fragile skin and is of neuropathy with, "Tingling extremity or feet." Further, the ed R80 was at, "Mild Risk" or e ulcers.		residents are assessed on admission and care plan initiated. All residents care plat 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	an	
	"Limited physical m "Potential for altera	ed 8/3/16, identified R80 had, obility in bed," and R80 had, tion in skin integrity." The care o, "Keep heels elevated in		sheets to make sure the current team sheets match the care plan for each resident. When there is a change in car the clinical coordinators (or designee) w update the team sheets and the care pla There will be an in-service regarding the	vill an.	
		Body Audit dated 8/15/16, no current pressures and her ed as, "Clear."		process of updating of care plan and tea sheets for all nursing the week of Octob 3, 2016.		
	During observation	of morning care on 8/31/16, at		Reoccurrence will be prevented by:		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/31/2016	
		00271	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AKE M	NNETONKA SHORES		DRELINE DF PARK, MN 3			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 23	2 900			
	 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." 		Weekly audits will be dor Coordinators. They will cl residents each week to m plans match team sheets services indicated on the being followed. The Correction will be mo a. The audits will be giv Administrator for review. b. Administrator for review. b. Administrator will rep QA Team. QA will determ audits c. The Clinical Administ responsible for compliance	hose 10% of the nake sure care and that the plan of care are onitored by: en to the Clinical ort audits to the ine frequency of rator will be		
	licensed practical n (LPN)-B stated R80 pressure ulcers" be and incontinence. unaware of any cor heels which would o aware of anything v stated if staff attem refused, it should b LPN-B stated there support" they had b previous night or m When interviewed a LPN-B stated R80's floated while she w	8/31/16, at 12:20 p.m. urse clinical coordinator) was at, "Slight risk for ecause of her impaired mobility LPN-B stated she was neerns for R80 concerning her cause them to be red, [I'm] not vrong with her heels." LPN-B pted to float her heels and she e documented however, was, "No documentation to been floated during the orning. again on 8/31/16, at 1:56 p.m. s heels should have been as in bed, or the nursing staff hented the reason why they				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00271	B. WING		08/31/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	INNETONKA SHORES		ORELINE DRIV PARK, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 24	2 900			
	a directive to, "Impl and to provide appr for pressure ulcers/ standards of care." general care guidel	Policy dated 8/2016, identified ement preventative measures; ropriate treatment modalities (injuries according to industry Further, the policy provided ines for staff to follow which neels off bed as indicated"				
	director of nursing (inservice staff abou	HOD OF CORRECTION: The (DON) or designee could it implementing the care plan a ulcer development, and then re compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			9/30/16
	residents shall, at a are legal rights for stay at the facility o treatment and main that these are desc written statement o responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga	tion about rights. Patients and admission, be told that there their protection during their r throughout their course of attenance in the community and ribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written o describe the right of a d or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in us. Reasonable				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKE MI	NNETONKA SHORES		RELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21800	accommodations s communication imp speak a language of facility policies, insp local health authori the written stateme to patients, residen chosen representat to the administrator person, consistent	age 25 hall be made for those with pairments and those who other than English. Current pection findings of state and ties, and further explanation of nt of rights shall be available ts, their guardians or their tives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to	21800			
	by: Based on interview facility failed to prov Medicare Non-Cov (R93) reviewed for Findings include: R93's progress not would be completing to assisted living or further recommend R93's medical reco	ent is not met as evidenced and document review, the vide the required Notice of erage for 1 of 3 residents liability notices. e dated 7/13/16, identified R93 og therapy and discharge back n 7/15/16. R93 had, "No lations for continued therapy." ard was reviewed. There was ad been provided a Notice of		Resident 93 was discharged prior adequate notice given related to fa and resident's wishes to discharge than anticipated end date of thera Corrective Action as it applies to coresidents: The policy and procede Medicare Denials was reviewed a current. To prevent reoccurrence residents the criteria for denial for Medicare benefits is reviewed dail meetings. This in-service for this g be held the week of 9/26/2016. S training and tool kits were created	amily e earlier py. other ure for nd is for other y at IDT group will pecific	
	Medicare Non-Cov required when their ended. During interview on social worker (LSW nursing home for th Medicare Part A co	Ad been provided a Notice of erage (CMS-10123) as Medicare coverage was 8/31/16, at 3:55 p.m. licensed /)-A stated R93 admitted to the herapy services under verage. R93 completed his nd was originally planned to		Reoccurrence will be prevented b will be done weekly by the Reside Services Director (LSW) or design audits will be reviewed monthly to for criteria of discharge to make s notices are given timely.	y: Audits nt nee. The check	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		00271	B. WING		08/31/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
AKE MI	NNETONKA SHORES		ORELINE DR PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
21800	Continued From pa	ige 26	21800			
	assisted living woul weekend. LSW-As with R93's family to Friday, 7/15/16, ins not provided a Noti	day, 7/16/16, however the ld not accept him on the stated a decision was made o move up his discharge to tead. LSW-A stated R93 was ce of Medicare Non-Coverage use R93, "Chose to go on his o the last day."		 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 audits c. The Administrator will be responsible for compliance. 	y of	
	The director of nurs inservice staff about of non-coverage tin compliance.	THOD OF CORRECTION: sing (DON) or designee could it providing Medicare notices nely, and then audit to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		10/7/16	
	Subd. 5. Courteous treatment. Patients and esidents 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.					
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure a dignified consistently provided for 1 of 3 riewed for dignity.		To correct the deficient practice for resident #80 LSW interviewed resident make sure we have proper understand of what time the resident would prefer rise and go to bed. Weekly check-ins resident services for this resident will	ing to	
	-	imum Data Set (MDS) dated		occur to ensure resident needs are bei met ongoing.	ng	

STATE FORM

KN7Z11

If continuation sheet 27 of 30

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		00271	B. WING		08/31/	2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
_AKE MI	INNETONKA SHORES		DRELINE DF PARK, MN 5			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLE DATE
21805	Continued From pa	ige 27	21805			
21003	7/25/16, identified F required extensive and was totally dep During interview on stated she did not f dignity because it s lag of time," in getti dressing. R80 state her then, "Leave the so R80 has to, "Lay someone to help fir this happens, "All th "Rejected and unca On 8/31/16, at 7:54 room with her call lip practical nurse (LPI turned off R80's cal cream to R80's legs ready to get up?" F waiting to get up?" F waiting to get up?" F waiting to get up," t would inform the nu 7:57 a.m. R80 agai outside the room. I turned off the call lip would be coming, " applied a warm was the room. At 8:25 a.m. R80 re assistance being of ready for the day as stated she was, "W had been waiting fo [a.m.]." R80 stated	R80 had intact cognition, assistance with bed mobility, endent on staff for transfers. 8/29/16, at 4:24 p.m. R80 eel staff treated her with eemed, "Like there's always a ng assistance with cares and ed the staff often start helping e room and not come back," / there on the bed waiting for hish dressing me." R80 stated he time," and it makes her feel, ared for." • a.m. R80 was in bed in her tight turned on. Licensed N)-B entered the room and Il light. LPN-B applied a s and asked her, "Are you R80 stated she had, "Been o which LPN-B stated she ursing assistant (NA) staff. At n turned on her call light LPN-B entered the room and ght and told R80 the NA staff In a minute." LPN-B then shcloth to R80's eyes and left		Corrective Action as it applies to residents: The policy and proced call light response and dignity we reviewed and are current. All resp preferences are assessed upon admission, minimally quarterly ar indicated with a change in request services from family or resident. are trained on timely response of lights and meeting resident request hire and minimally annually with a training. We will do an in-service review the importance of resident preferences and Dignity policy du week of October 3, 2016. This to be discussed at resident council in October as to resident preferent timeliness of services. Househol residents will be interviewed by L learn preference on what time the residents would like to get up and sleep each day. A Committee has formed to discuss on going staffin patterns in the morning/evening a we can best meet our residents preferences. Reoccurrence will be prevented to Weekly audits will be done on 10 residents to ensure resident s preferences are being met when to preferred wake times and the to they are going to bed. Residents preferred wake times will be adde NAR team sheets. Audits of time	dure for re- sident ad as st of All staff call ests upon annual e to t uring the opic will upcoming nce and d SW to e d go to as been ng and how Dy: % of the it comes times ed to ely	
	"Lonelier because I dining room]." At 8	before, and it makes her feel, have to eat by myself [in the :29 a.m. (thirty five minutes egan) NA-A entered R80's		response rates will also be condu ensure ongoing needs are being timely.		

KN7Z11

If continuation sheet 28 of 30

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00271		B. WING		08/3	08/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE			
LAKE MI	NNETONKA SHORES		DRELINE DR PARK, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ge 28	21805				
	 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." 			21805 The Correction will be mon a. The audits will be given Administrator for review. b. Administrator will repor QA Team. QA will determin audits c. The Administrator will b for compliance.	en to the ort audits to the ine frequency of		
	resident should be an environment tha	icy dated 12/2014, identified cared for, "In a manner and in t promotes maintenance nt of each resident's quality of					
	The director of nurs staff about ensuring	HOD OF CORRECTION: sing (DON) could inservice g cares are initiated and each resident, then complete sure compliance.					
		R CORRECTION: Twenty-one					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		- (X3) DATE SURVEY COMPLETED	
		00271	B. WING		08/	31/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AKE MI	NNETONKA SHORES	S	ORELINE DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 29	21805			
	(21) days.					



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Lake Minnetonka Shores September 21, 2016 Page 2

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