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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QN8I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00234

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245606**

2.STATE VENDOR OR MEDICAID NO.
(L2) **519842900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE MINNETONKA CARE CENTER**
(L4) **20395 SUMMERVILLE ROAD**
(L5) **DEEPHAVEN, MN** (L6) **55331**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/17/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **21** (L18)

13.Total Certified Beds **21** (L17)

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

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

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

* Code: **A, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	21			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, HFE NEII 12/16/16
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/16/2016
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/02/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/26/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5606

On October 28, 2016, as authorized by CMS Region V Office, we informed the facility that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective November 25, 2016.

Also our notice of October 28, 2016 notified the facility of the two year NATCEP prohibition, begiining November 25, 2016.

This was based on deficiecies cited by this Department for a standard survey completed on August 25, 2016 and lack of verification of compliance with the LSC deficiencies.

On December 12, 2016 the Minnesota Department of Publix Safety completed a Post Certification Revisit (PCR) to verify compliance with deficiencies issued pursuan tto teh August 25, 2016 standard survey. Based on the PCR adn FSES, we have deteremined the deficiencies had benn corrected, effective October 17, 2016.

As a result of the revisit findings. the Department recommended the following action to the CMS RO as it relates to our notice of October 28, 2016:

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective November 25, 2016, be rescinded.

Since the primary trigger for the loss of NATCEP did not go into effect, the NATCEP prohibition has been rescinded.

The LSC deficiencies cited at K0012 and K0039 have been e verified for compliance based on FSES.

The facility has requested a waiver of health deficiency cited at F458, Bedrooms Measure at least 80 Sq Ft / Resident. Approval of the waiver request has been recommended.

Refer to the CMS 2567b for both health and life safety code.

Effective October 17, 2016, the facility is certified for 21 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245606

December 16, 2016

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

Dear Mr. Sprinkel:

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

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

Effective October 17, 2016 the above facility is certified for:

21 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 21 skilled nursing facility beds.

Your request for waiver of F458 been approved based on the submitted documentation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

December 16, 2016

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number F5606024

Dear Mr. Sprinkel:

On October 28, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 25, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 28, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 25, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on August 25, 2016, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our October 28, 2016 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 12, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 25, 2016, as of October 17, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 28, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 25, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 25, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 25, 2016, is to be rescinded.

In our letter of October 28, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 25, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 17, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the health deficiency cited under F458 at the time of the August 25, 2016 standard survey has been approved.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5694 9933

October 28, 2016

Mr Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number S5606026

Dear Mr. Sprinkel:

On September 15, 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 25, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 17, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 25, 2016.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 25, 2016 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard extended survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 25, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 25, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 25, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Lake Minnetonka Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 25, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the October 17, 2016 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 February 25, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245606 Y1	A. Building B. Wing Y2	10/17/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(l)	Completed
LSC	10/17/2016	LSC	10/17/2016	LSC	10/17/2016
ID Prefix F0334	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	10/17/2016	LSC	09/30/2016	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	12/16/2016	15507	10/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245606 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	12/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0012	10/26/2016	LSC K0039	10/26/2016	LSC K0052	08/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0054	09/08/2016	LSC K0064	09/26/2016	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	12/16/2016	37009	12/12/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/23/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

Healthcare Survey Protection

Lauzon

Life Safety Consulting, LLC

29606-41 Street
Salem, WI 53168

"Your Protective Shield
In the Code War"

262-945-4567

Lauzon.lsc@gmail.com
http:// Lauzon-LSC.com

November 7, 2016

2016 FIRE SAFETY EQUIVILENCY SYSTEM ASSESSMENT

By Bill Lauzon, PE

Enclosed are the submittal documents that support the assessment, under the FSES program of CMS, of the outstanding life safety deficiencies at the Lake Minnetonka Care Center that are unable to be corrected under normal means.

The documents demonstrate the SUCCESSFUL result of the assessment and shows that Lake Minnetonka has successfully passed the FSES assessment and is considered to have an equivalent level of the safety to that required by the 2000 Life Safety Code.

The following documents are included in this submittal:

1 - FSES Overview
2 - Parameter Overview
3 –Zone Calculation Sheets & Drawing
    Smoke Compartment #1 – (basement)
    Smoke Compartment #2 – (1st floor)
    Smoke Compartment #3 –(2nd Floor)
4 - Verification Report, CMS form 2786 – Oct 14, 2016
5 - Resident & Staff Information
6 - License of Bed Count
7 - Qualifications of Bill Lauzon for FSES assessment
8 – Life Safety Plans

If there are any questions concerning this FSES, please contact me via phone or e-mail.

Sincerely,

Bill Lauzon

Bill Lauzon, PE
Lauzon Life Safety Consulting, LLC
262-945-4567
Lauzon.lsc@gmail.com

Healthcare Survey Protection

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http:// Lauzon-LSC.com

FIRE SAFETY EVALUATION SYSTEM SUBMITTAL

An FSES is NOT intended to be an all-encompassing alternative to compliance with the requirements of the Life Safety Code. Points for fire alarm and sprinkler systems are only available if the systems are correctly installed and fully maintained.

FACILITY: LAKE MINNETONKA CARE CENTER Provider #: 245606

1. FSES Date: Nov 8, 2016 Most Recent Verification Survey Date: October 14, 2016 Most Recent CMS Survey Date: Aug 28, 2016

2. Occupant Info:	Residents do not use the basement level. All residents are 65 or older, and are mobile and do not use wheelchairs or walkers. All residents are mentally challenged and require assistance to evacuate.
3. Construction Type:	Building is wood framed, without protection to structural members . Construction Type is V(000). 1920 Original structure, Additions in ~1950 and 1960 have same construction. Building is fully sprinkled w/corridor smoke detection and 2nd floor resident rooms
4. Smoke Zone Info:	There are 11 residents on the 1st floor and 10 on the second floor. The code does not require any smoke barrier walls for this level of occupancy. Each floor is considered a separate zone. Bsmt=1, 1st floor=2, 2nd floor=3
5. Table 8 Info:	All utilities are code compliant. The facility POC has implemented quarterly fire drills that include transmission of the DACT signal to the monitoring company.

6. CMS Survey Deficiency Summary: ←Method of POC Resolution→

Deficiency	1. Corrected	2. Waived	3. FSES	Comments
K12 Story V(000)			FSES Submittal	
K39-Narrow Corridor			FSES Submittal	
K52-Missing Annual Alarm Inspection	08/26/2016			Facility hired an experienced fire alarm inspector to perform the required annual inspection on 8/26/2016. The documentation was reviewed during the Oct 14 verification inspection and found to be complete and acceptable. No deficiencies were discovered during the inspection
K54-Missing Sensitivity Test	09/08/2016			Facility hired an experienced fire alarm inspector to replace all smoke detectors on 09/08/2016. , rather than merely test them. The documentation was reviewed during the Oct 14 verification inspection and found to be complete and acceptable. No deficiencies were discovered during the inspection
K64-Fire Extinguisher Inspection	09/13/2016			Facility performed the required monthly inspection on the basement extinguisher 09/163/2016. The documentation was reviewed during the Oct 14 verification inspection and found to be complete and acceptable. No deficiencies were discovered during the inspection

Prepared on behalf of the owner,

Bill Lauzon

Bill Lauzon, PE
Wis Professional Engr #37869-06; former CMS Surveyor # 22219
Lauzon Life Safety Consulting, LLC

Healthcare Survey Protection

Lauzon

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"Your Protective Shield
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Salem, WI 53168

Lauzon.lsc@gmail.com
http:// Lauzon-LSC.com

QUALIFICATIONS FOR FSES PREPARATION
Bill Lauzon, PE

Bill Lauzon is a Wisconsin registered Professional Engineer (#37869-6), who by training and experience, is qualified to evaluate health care facilities for compliance with the Life Safety Code (2000 edition), via the Alternative Approach, NFPA 101A (2001 edition), using the FSES system.

1. Mr. Lauzon is self-employed with Lauzon Life Safety Consulting, LLC and provides assistance to all health care provider types to help them improve their compliance with the Life Safety Code and the Wisconsin Commercial Building Codes (2009 IBC). He surveys dozens of facilities a year, assists with Plans of Corrections, reviews construction plans, and performs construction inspections for code compliance.

2. Mr. Lauzon received training on FSES, NFPA 101A for health care from CMS in December, 2006 in Baltimore Maryland. See attached certification of education.

3. Mr. Lauzon was employed as a health care surveyor (CMS Surveyor #22219) for the Wisconsin Department of Health, Division of Quality Assurance from 2006 to 2011. During that time he surveyed all provider types, including hospitals, critical access hospitals, nursing homes, surgical centers, end stage renal dialysis facilities, and community based residential facilities. During this time, he prepared and reviewed a number of FSES submittals.

4. Mr. Lauzon served as the Wisconsin Fire Authority from 2009-2011, with the responsibility of reviewing all waiver and FSES submittals for final state agency approval prior to forwarding to the CMS regional office V. During this time, he reviewed all FSES submittals by all provider types.

5. Mr. Lauzon worked in the private sector for 28 years as the director of facilities and construction at several private hospitals, including nursing home operations. During this time, he was inherently involved with the construction of over $150 million of structures and maintenance of facilities as old as 1918.

6. Mr. Lauzon worked in the federal sector for 5 years for the Veteran's Administration. During this time, he conducted life safety compliance surveys at private nursing homes that received VA funding for care of veterans in Wisconsin and North Dakota and at all VA health care and office facilities in Wisconsin and Upper Michigan.

7. Mr. Lauzon has received training on all editions of the Life Safety Code from 1967 to the 2000 edition. He has attended the intensive NFPA-sponsored training on the full Life Safety Code, CMS training on NFPA 99 and 101, and a UW Extension course on NFPA 13-Sprinkler Installation.

INTRODUCTION

On August 23, 2016 the Minnesota Department of Health Services conducted a CMS compliance survey at Lake Minnetonka care Center in Deephaven, Mn. A Statement of Deficiencies (SOD) report identified five life safety deficiencies (K-012, 039, 054, and 064). The facility developed a Plan of Correction (POC) to resolve three (K-052, 054, and 062) of the citations, and proposed resolution of two (K-012 and 039) via a Fire Safety Evaluation System (FSES) analysis.

The FSES is a point system consisting of 13 distinct safety parameters with defined values. An equivalent level of safety can be demonstrated through arrangement of the safety parameters differing from the exact requirements of the Life Safety Code. NFPA 101 (2000) Life Safety Code has been used for this analysis. The FSES is described in NFPA 101A (2001).

Lauzon Life Safety Consulting, LLC was retained to perform the FSES analysis of the facility. A full compliance survey of the building was conducted on October 14, 2016 by Heather Werner to evaluate the existing conditions of the building and verify the correction of deficiencies from the August, 201 MHS survey.

This report contains the findings of the October 14 verification survey, and the FSES calculation sheets, which demonstrates a **passing** FSES score for each zone under existing conditions. It shows that the healthcare building has sufficient safety features to meet the requirements the Life Safety Code, via alternative methods.

BUILDING DESCRIPTION & SMOKE ZONES

Lake Minnetonka is a two story wood frame building, with full basement, with Type V(000) construction, subdivided into three smoke compartments. The floor plan of each zone is attached to the evaluation packet for the zone.

CONDITIONS OBSERVED ON SURVEY DATE of OCTOBER 14, 2016

Typical of each zone (except as noted)

Patient Mobility (Table 1, Parameter 1) This parameter has been evaluated as mobile for each zone. A letter from the facility (attached) indicates that all residents are capable of being relocated in accordance with the facility's policies and procedures in the event of an emergency, and that there are no residents on life support systems.

Patient Density (Table 1, Parameter 2) This parameter has been evaluated for each zone in accordance with NFPA 101A section 4.5.2.2 which states "The density of patients is the number of patients who could potentially be housed in the zone. The patient count should be based on the number of assignable beds in the zone, assuming that they might all be occupied at the time of the fire emergency". Bed counts are provided on attached floor plans.

Ratio of Patients to Attendants (Table 1, Parameter 4) This parameter has been evaluated as > 10/1 for each zone. A letter from the facility (attached) outlines nursing staff levels per unit per shift.

LIFE SAFETY PARAMETER EVALUATION (Table 4)

Safety Parameter 1: Construction

The Minnesota Dept of Health identified the construction type of the building as Type V(000) combustible construction under K-000 on the Statement of Deficiencies. Lauzon Life Safety Consulting confirmed during the October 14 survey that the construction type was Type V(000) and is not permitted for a two story building, per LSC Table 19. 1.6.1.

Parameters 2 and 3: Interior Finish

All interior finishes, with the exception of incidental wood trim, were observed to be consistent with Class A finishes. These parameters have been evaluated as "Class A".

Parameter 4: Corridor Partitions and Walls

Corridor walls on the first and second floors were observed to be constructed of 3/8 inch layer of plaster board and 1/2 inch layer of gypsum plaster coating on each side of wood studs spaced at 16" on center. This assembly is consistent with a 45 minute rated assembly per documentation available from

NIST.

Parameter 5: Doors to Corridor
Corridor doors were generally observed to be of 1¾ inch thick solid core construction. Additionally, a small quantity of doors within the facility was observed to be of hollow core construction. Zones containing hollow core doors are evaluated per NFPA 101A section 4.6.5.2 which states "Doors that are not deficient as described in 4.6.5.1 but that do not meet the requirements of 4.6.5.3 shall be classified as less than 20-minute fire protection rating".

Parameter 6: Zone Dimensions
Zone dimensions were field measured in accordance with the requirements of NFPA 101 (2000) section 19.3.7.1.

Parameter 7: Vertical Openings
No deficiencies observed.

Parameter 8: Hazardous Areas
No deficiencies observed

Parameter 9: Smoke Control
At the time of the October 14 verification survey, all basement, first and second floor zones were observed to be served by compliant smoke barriers and have been evaluated as "smoke barrier serves zone".

Parameter 10: Emergency Movement Routes
No deficiencies observed

Parameter 11: Manual Fire Alarm
The building is served by a manual fire alarm system. The fire alarm system is monitored by a central station monitoring service. Manual pull stations are provided at each exit in the natural path of egress as required. Audible notification appliances are provided throughout the facility. Each zone is evaluated as "Manual Fire Alarm with FD Connection".

Parameter 12: Smoke Detection and Alarm
The Facility is protected by a fire alarm system which has smoke detection in all exit corridors, and spaces open to exit corridors.

Parameter 13: Automatic Sprinklers
No deficiencies observed

TABLE 8 Evaluation

The equivalency covered by Tables 1 through 7 includes the majority of the considerations covered by the Life Safety Code. Some considerations, not evaluated by this method, are considered separately in Table 8, the "Facility Fire Safety Requirements Worksheet."

CONCLUSION

As this report demonstrates, the building achieves a passing score on a Fire Safety Evaluation System (FSES) under existing conditions on the date the facility was evaluated by LSR.

Prepared by:
Bill Lauzon

Bill Lauzon, PE
Lauzon Life Safety Consulting, LLC

ZONE 01 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LAKE MINNETONKA CARE CENTER	01

ZONE(S) EVALUATED: BASEMENT

PROVIDER/VENDOR NO.	DATE OF SURVEY
245606	CMS: 08/23/16; FSES: 10/14/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.

A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0 ✔	1.6 ☐	3.2 ☐	4.5 ☐
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0 ✔	1.2 ☐	1.5 ☐	2.0 ☐
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1 ☐	1.2 ☐	1.4 ☐	1.6 ☐	1.6 ✔
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0 ✔	1.1 ☐	1.2 ☐	1.5 ☐	4.0 ☐
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0 ✔		1.2 ☐		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.

A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.

B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1	X	1	X	1.6	X	1	X	1	=	1.60

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.

B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.

C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.60	=	1

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

SURVEYOR SIGNATURE	TITLE	DATE
Bill Lauzon, PE (electronic)	LS Consultant	11/08/2016
FIRE AUTHORITY SIGNATURE Thomas Linhoff 12424	TITLE FIRE SAFETY SUPERVISOR	DATE 11-09-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-7
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2 ☐	0 ☐	-2 ☐	0 ☐	0 ☐	2 ☐	2 ☐	
Second	-7 ✔	-2 ☐	-4 ☐	-2 ☐	-2 ☐	2 ☐	4 ☐	
Third	-9 ☐	-7 ☐	-9 ☐	-7 ☐	-7 ☐	2 ☐	4 ☐	
4th and Above	-13 ☐	-7 ☐	-13 ☐	-7 ☐	-9 ☐	-7 ☐	4 ☐	
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A					3
	-5(0)[f] ☐	0(3)[f] ☐	3 ✔					
3. Interior Finish (Rooms)	Class C	Class B	Class A					3
	-3(1)[f] ☐	1(3)[f] ☐	3 ✔					
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour				0
	-10(0)[a] ☐	0 ✔	1(0)[a] ☐	2(0)[a] ☐				
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.				0
	-10 ☐	0 ✔	1(0)[d] ☐	2(0)[d] ☐				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b] ☐	-4(0)[b] ☐	-2(0)[b] ☐	-2(0)[c] ☐	0 ☐	1 ✔		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					0
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14 ☐	-10 ☐	0 ✔	2(0)[e] ☐	3(0)[e] ☐			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11 ☐	-5 ☐	-6 ☐	-2 ☐	0 ✔			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					0
	-5(0)[c] ✔	0 ☐	3 ☐					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)			
	-8 ☐	-2 ☐	0 ✔	1 ☐	5 ☐			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					2
			W/O F.D. Conn.	W/F.D. Conn				
	-4 ☐		1 ☐	2 ✔				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			5
	0(3)[g] ☐	2(3)[g] ☐	3(3)[g] ☐	4 ☐	5 ✔			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	0 ☐	8 ☐	10 ✔					

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked “000” or “200”)

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 9	S_2= 10	S_3= 14	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☐	15(12)[a] ☐	4 ☐	8(5)[a] ☐	1 ☐
2nd or 3rd story[b]	15 ☐	9 ☑	17(14)[a] ☐	6 ☑	10(7)[a] ☐	3 ☑
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 9	-	S_a 9	=	C 0	✔	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 10	-	S_b 6	=	E 4	✔	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 14	-	S_c 3	=	P 11	✔	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	-	R 1	=	G 16	✔	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✔		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✔
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✔		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✔		
E.	There are no flue-fed incinerators.	✔		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✔		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✔		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✔		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✔		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✔		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✔		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✔

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

ZONE 01 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LAKE MINNETONKA CARE CENTER	01

ZONE(S) EVALUATED: BASEMENT

PROVIDER/VENDOR NO.	DATE OF SURVEY
245606	CMS: 08/23/16; FSES: 10/14/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.

A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0 ✔	1.6	3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0 ✔	1.2	1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	1.6 ✔
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0 ✔	1.1	1.2	1.5	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0 ✔		1.2		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.

A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.

B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1	X	1	X	1.6	X	1	X	1	=	1.60

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.

B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.

C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.60	=	1

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

SURVEYOR SIGNATURE	TITLE	DATE
BILL LAUZON, PE (electronic)	LS CONSULTANT	11/08/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
	FIRE SAFETY SUPERVISOR	11-09-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-7
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2 ☐	0 ☐	-2 ☐	0 ☐	0 ☐	2 ☐	2 ☐	
Second	-7 ✔	-2 ☐	-4 ☐	-2 ☐	-2 ☐	2 ☐	4 ☐	
Third	-9 ☐	-7 ☐	-9 ☐	-7 ☐	-7 ☐	2 ☐	4 ☐	
4th and Above	-13 ☐	-7 ☐	-13 ☐	-7 ☐	-9 ☐	-7 ☐	4 ☐	
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A					3
	-5(0)[f] ☐	0(3)[f] ☐	3 ✔					
3. Interior Finish (Rooms)	Class C	Class B	Class A					3
	-3(1)[f] ☐	1(3)[f] ☐	3 ✔					
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour				0
	-10(0)[a] ☐	0 ✔	1(0)[a] ☐	2(0)[a] ☐				
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.				0
	-10 ☐	0 ✔	1(0)[d] ☐	2(0)[d] ☐				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b] ☐	-4(0)[b] ☐	-2(0)[b] ☐	-2(0)[c] ☐	0 ☐	1 ✔		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					0
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14 ☐	-10 ☐	0 ✔	2(0)[e] ☐	3(0)[e] ☐			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11 ☐	-5 ☐	-6 ☐	-2 ☐	0 ✔			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					0
	-5(0)[c] ✔	0 ☐	3 ☐					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)			
	-8 ☐	-2 ☐	0 ✔	1 ☐	5 ☐			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					2
			W/O F.D. Conn.	W/F.D. Conn				
	-4 ☐		1 ☐	2 ✔				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			5
	0(3)[g] ☐	2(3)[g] ☐	3(3)[g] ☐	4 ☐	5 ✔			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	0 ☐	8 ☐	10 ✔					

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked “000” or “200”)

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 9	S_2= 10	S_3= 14	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☐	15(12)[a] ☐	4 ☐	8(5)[a] ☐	1 ☐
2nd or 3rd story[b]	15 ☐	9 ☑	17(14)[a] ☐	6 ☑	10(7)[a] ☐	3 ☑
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 9	-	S_a 9	=	C 0	✔	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 10	-	S_b 6	=	E 4	✔	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 14	-	S_c 3	=	P 11	✔	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	-	R 1	=	G 16	✔	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✔		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✔
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✔		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✔		
E.	There are no flue-fed incinerators.	✔		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✔		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✔		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✔		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✔		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✔		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✔		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✔

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

ZONE 02 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LAKE MINNETONKA CARE CENTER	01

ZONE(S) EVALUATED: FIRST FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
245606	CMS: 08/23/16; FSES: 10/14/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.

A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0 ☐	1.6 ☑	3.2 ☐	4.5 ☐
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0 ☐	1.2 ☐	1.5 ☑	2.0 ☐
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above / Basements
	Risk Factor	1.1 ☑	1.2 ☐	1.4 ☐	1.6 ☐ / 1.6 ☐
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1 — One or More / None
	Risk Factor	1.0 ☐	1.1 ☐	1.2 ☐	1.5 ☑ / 4.0 ☐
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger	
	Risk Factor	1.0 ☐		1.2 ☑	

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.

A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.

B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.6	X	1.5	X	1.1	X	1.5	X	1.2	=	4.75

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.

B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.

C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	4.75	=	2.8

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

SURVEYOR SIGNATURE	TITLE	DATE
BILL LAUZON, PE (electronic)	LS CONSULTANT	11/08/2016
FIRE AUTHORITY SIGNATURE Thomas Linhoff 12424	TITLE FIRE SAFETY SUPERVISOR	DATE 11-09-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-2
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2 ✔	0	-2	0	0	2	2	
Second	-7	-2	-4	-2	-2	2	4	
Third	-9	-7	-9	-7	-7	2	4	
4th and Above	-13	-7	-13	-7	-9	-7	4	
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A					3
	-5(0)[f]	0(3)[f]	3 ✔					
3. Interior Finish (Rooms)	Class C	Class B	Class A					3
	-3(1)[f]	1(3)[f]	3 ✔					
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	≥1/2 to <1 hour	≥1 hour				1
	-10(0)[a]	0	1(0)[a] ✔	2(0)[a]				
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.				1
	-10	0	1(0)[d] ✔	2(0)[d]				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1 ✔		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					0
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14	-10	0 ✔	2(0)[e]	3(0)[e]			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11	-5	-6	-2	0 ✔			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					0
	-5(0)[c] ✔	0	3					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						-2
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)			
	-8	-2 ✔	0	1	5			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					2
			W/O F.D. Conn.	W/F.D. Conn				
	-4		1	2 ✔				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			2
	0(3)[g]	2(3)[g] ✔	3(3)[g]	4	5			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	0	8	10 ✔					

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked “000” or “200”)

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	**S_1=** 16	**S_2=** 12	**S_3=** 10	**S_4=** 19

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☑	15(12)[a] ☐	4 ☑	8(5)[a] ☐	1 ☑
2nd or 3rd story[b]	15 ☐	9 ☐	17(14)[a] ☐	6 ☐	10(7)[a] ☐	3 ☐
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 16	-	S_a 5	=	C 11	✔	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 12	-	S_b 4	=	E 8	✔	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 10	-	S_c 1	=	P 9	✔	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 19	-	R 2.8	=	G 16	✔	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✔		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✔
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✔		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✔		
E.	There are no flue-fed incinerators.	✔		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✔		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✔		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✔		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✔		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✔		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✔		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✔

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

ZONE 03 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY LAKE MINNETONKA CARE CENTER	BUILDING 01
ZONE(S) EVALUATED SECOND FLOOR	
PROVIDER/VENDOR NO. 245606	DATE OF SURVEY CMS: 08/23/16; FSES: 10/14/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0 ☐	1.6 ✔	3.2 ☐	4.5 ☐
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0 ☐	1.2 ✔	1.5 ☐	2.0 ☐
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1 ☐	1.2 ✔	1.4 ☐	1.6 ☐	1.6 ☐
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0 ☐	1.1 ☐	1.2 ☐	1.5 ✔	4.0 ☐
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0 ☐		1.2 ✔		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.6	X	1.2	X	1.2	X	1.5	X	1.2	=	4.15

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X ☐	=	☐

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X 4.15	=	3

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

SURVEYOR SIGNATURE BILL LAUZON. PE (electronic)	TITLE LS Consultant	DATE 11/08/2016
FIRE AUTHORITY SIGNATURE Thomas Linhoff 12424	TITLE FIRE SAFETY SUPERVISOR	DATE 11-09-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-7
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2 ☐	0 ☐	-2 ☐	0 ☐	0 ☐	2 ☐	2 ☐	
Second	-7 ✔	-2 ☐	-4 ☐	-2 ☐	-2 ☐	2 ☐	4 ☐	
Third	-9 ☐	-7 ☐	-9 ☐	-7 ☐	-7 ☐	2 ☐	4 ☐	
4th and Above	-13 ☐	-7 ☐	-13 ☐	-7 ☐	-9 ☐	-7 ☐	4 ☐	
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A					3
	-5(0)[f] ☐	0(3)[f] ☐	3 ✔					
3. Interior Finish (Rooms)	Class C	Class B	Class A					3
	-3(1)[f] ☐	1(3)[f] ☐	3 ✔					
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	≥1/2 to <1 hour	≥1 hour				1
	-10(0)[a] ☐	0 ☐	1(0)[a] ✔	2(0)[a] ☐				
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.				1
	-10 ☐	0 ☐	1(0)[d] ✔	2(0)[d] ☐				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b] ☐	-4(0)[b] ☐	-2(0)[b] ☐	-2(0)[c] ☐	0 ☐	1 ✔		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					0
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14 ☐	-10 ☐	0 ✔	2(0)[e] ☐	3(0)[e] ☐			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11 ☐	-5 ☐	-6 ☐	-2 ☐	0 ✔			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					0
	-5(0)[c] ✔	0 ☐	3 ☐					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						-2
			W/O Horizontal Exit(s)	Horizontal Exit(s)				
	-8 ☐	Deficient -2 ✔	0 ☐	1 ☐	Direct Exit(s) 5 ☐			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					2
			W/O F.D. Conn.	W/F.D. Conn				
	-4 ☐		1 ☐	2 ✔				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			4
	0(3)[g] ☐	2(3)[g] ☐	3(3)[g] ☐	4 ✔	5 ☐			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	0 ☐	8 ☐	10 ✔					

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked “000” or “200”)

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 11	S_2= 9	S_3= 12	S_4= 16

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☐	15(12)[a] ☐	4 ☐	8(5)[a] ☐	1 ☐
2nd or 3rd story[b]	15 ☐	9 ☑	17(14)[a] ☐	6 ☑	10(7)[a] ☐	3 ☑
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 11	−	S_a 9	= C 2	✔	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 9	−	S_b 6	= E 3	✔	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 12	−	S_c 3	= P 9	✔	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 16	−	R 3	= G 13	✔	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✔		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✔
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✔		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✔		
E.	There are no flue-fed incinerators.	✔		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✔		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✔		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✔		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✔		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✔		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✔		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✔

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QN8I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00234

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245606**
2.STATE VENDOR OR MEDICAID NO.
(L2) **519842900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE MINNETONKA CARE CENTER**
(L4) **20395 SUMMERVILLE ROAD**
(L5) **DEEPHAVEN, MN** (L6) **55331**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **21** (L18)
13.Total Certified Beds **21** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	21			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NEII 10/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/02/1992** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5606

At the time of the standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required.

The facility has requested a waiver of health deficiency cited at F458, Bedrooms Measure at least 80 Sq Ft / Resident. Approval of the waiver request has been recommended.

The LSC deficiencies cited at K0012 and K0039 will be verified for compliance based on FSES.

Refer to the CMS-2567 for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit(PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5637

September 15, 2016

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number S5606026

Dear Mr. Sprinkel:

On August 25, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 4, 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 4, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F-282 10-17-16 R12s OBP has been taken and will be taken on a monthly basis. R18s Discus will be completed by due date. R20s DISCUS is included with this response. Also, the facility's care plan policy is also included and was available at the time of the survey.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensue care plans were followed related to potential medication side effects for 3 of 5 residents (R12, R18, R20) who were reviewed for unnecessary medication use. Findings include: R12's careplan dated 7/14/16, indicated the resident was at risk for falls due to psychotropic med use, orthostatic blood pressure and weakness. The care plan instructed staff as follows: "Orthostatic blood pressure to be taken monthly and provided to the psychiatrist and MD [physician] at next visit."	F 282	Orthostatic blood pressures will be completed on a monthly basis on every resident. The results will be given to each resident's primary Physician and Psychiatrist at their next visit. A DISCUS will be completed by the due date on all residents for whom one is due. This will be monitored by the DON for completion and compliance.	

POC accepted Lisa Santho 10/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary M. Bartlett | TITLE: Administrator | (X6) DATE: 9-27-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 R12's physician orders dated 6/3/16, indicated: Metoprolol Tartrate 12.5 milligrams (mg) twice daily for atherosclerotic heart disease. Staff was directed to hold the medicine if the resident's heart rate was below 44 or systolic blood pressure below 90. The resident was also prescribed the antipsychotic medication, Invega 234 intramuscularly every 30 days for bipolar depression (start date 1/6/16) and divalproex sodium extended release (anticonvulsant commonly used to alter behavior) 1500 mg at bedtime for bipolar depression (start date 2/4/14). The MARs for R12 revealed OBPs had not been taken in the months of 5/16 and 8/16. Available OBPs showed R12 experienced a drop in systolic and diastolic pressures, which could have contributed to an increased risk for falls. A physician note from a 6/16, physician visit indicated R12 "struggling with Hypotension since his May hospitalization." R18's 7/21/15, care plan indicated the resident had impaired cognitive function related to impaired decision making and dementia and need for close supervision. The use of psychotropic medications was noted, and the care plan included interventions for "DISCUS to be completed every per facility policy" and to monitor, document and report any adverse reactions including tardive dyskinesia. Physician orders for R18 indicated an order for the antipsychotics Risperidone 6 mg at bedtime (start date 2/2/16) for bipolar disorder and Abilify 15 mg in the morning schizoaffective disorder (start date 2/3/16). R18's also had physician orders for the antidepressant (commonly used to	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 promote sleep) Trazodone HCL 100 mg at bedtime (start date 2/12/15) as well as hydroxyzine pamoate 25 mg every 4 hours as needed for anxiety or agitation. The following morning at 8:32 a.m. the DON verified R18's last DISCUS completed was 4/17/15, and was overdue. R20's care plan dated 7/30/15, indicated R20 was on a medication regime including the antipsychotic, Abilify. R20's goal was to be free from serious side effects of psychotropic medications. Staff interventions were to administer antipsychotic medication as ordered, DISCUS to be completed per facility policy every six months, however, a current DISCUS was not located in the resident's record. During an interview on 8/24/16, at 10:14 a.m. the DON stated R20 had a DISCUS completed on 7/23/15 with a score of 7, indicating TD. The DON explained she did not have R20's current DISCUS results, but the resident was scheduled to see her physician the following week. The DON provided copies of all of R20's DISCUS assessments dated 7/23/15 and 6/4/13. On 8/25/16, at 9:37 a.m. the DON stated she expected staff to follow residents' care plans. A care planning was requested by the facility but was not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 3 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 observation, interview and document review the facility failed to provide adequate pain relief for 1 of 1 resident (R4) reviewed for pain. Findings include: R4 was observed lying on his bed listening to music on 8/22/16, at 6:40 p.m. R4 was then interviewed and reported, "I have continuous pain in my groin area everyday." He explained he had chronic groin pain for many years. Prior to his admission to the facility "I use to get Oxycodone [narcotic pain medication] which helped the pain go away but now I only get Tylenol [for mild to moderate pain] and maybe some gabapentin [anticonvulsant commonly used to treat pain]. R4 was observed on 8/23/16, at 12:23 p.m. walking into the dining room for lunch and eating his meal, and without talking to others in the room, bussed his dishes and returned to his room. During a follow up interview on 8/23/16, at 1:58 p.m. R4 stated his daily pain level without pain medication was 7 or 8 out of 10 on (0 being no pain and 10 excruciating pain). R4 explained when he got Tylenol or ibuprofen the pain dropped to a 5 or 6 out of 10. He also reported,	F 309	F-309 10-17-16 R4 has an order for an abdominal binder, his insurance will not pay for it and he does not wish to pay for it stating "I will just wait for now." Medica was informed and they are asking for information from resident's physician to determine the medically necessity of it. When R4 requested prn tylenol on 7/7 it is charted that "Resident requested pain medication for chronic hernia pain." It was effective. On 7/26 "resident requested pain medication for chronic hernia pain rated a 4 on a scale of 1-10, administration was effective. On 7/27 "resident requested pain medication for chronic hernia pain" administration was	

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F 309	Continued From page 4 "The pain is better if I get scheduled gabapentin. In the past I had an abdominal binder. The director of nursing [DON] talked about one, but nothing came about it." R4 said he felt the binder would help his pain, and expressed interest in obtaining one. A pain assessment for R4 at the time of admission and dated 1/19/16, indicated chronic abdominal pain rated 3 out of 5 on a scale of 0-5. No other assessment was available. Behavioral charting for all three shifts during the months of 6/16 and 5/16, indicated R4 displayed behaviors of "Dr. Shopping/Drug seeking" twice a month. R4's quarterly Minimum Data Set (MDS) dated 7/28/16, indicated R4 was cognitively intact, independent in activity of daily living, presented no behavioral issues including rejection of cares. The MDS indicated R4 had diagnoses including schizophrenia, anxiety, depression, and ventral hernia. R4's care plan dated 3/7 and 3/8/16, indicated an alteration in gastrointestinal status and chronic pain related to an inguinal abdominal hernia with looping of his bowels. The goal was for R4 to have pain control and to verbalize adequate relief of pain. Staff interventions included providing medications as ordered by the physician, evaluating the effectiveness of pain interventions, and reviewing the resident's satisfaction with results of interventions, and to notify the physician if the interventions were ineffective. Physician orders for R4 dated 7/14/16, indicated the resident was supposed to utilize an abdominal support band as needed (PRN) for groin pain dated 3/15/16. R4's medication administration	F 309	effective. This was found in the progress notes for these dates at the time of the survey. On 5/24 the order states that an abdominal binder from medical supply is desired and physician will have their social service designee check into this. On 8/5 he was seen by psychologist Dr. Linda Goldetsky who states patient's "focus on medication fits the somatic preoccupation with lack of insight connected to his persistent mental illness." "The apathy type lethargy is more a set personality pattern associated to the schizophrenia diagnosis." On 7/8 he was also seen by Linda Goldetsky R4 "continues to seek new medical doctor for goal	

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F 309	Continued From page 5 record (MAR) indicated orders for gabapentin 100 milligrams (mg) twice daily and three times daily PRN, ibuprofen 600 mg with meals, Tylenol 325 mg three times daily and 650 mg PRN at bed time. R4's MAR for the month of 8/16, indicated R4 only received three doses of gabapentin PRN in 7/16 (7/14, 7/18, and 7/19/16). In addition, R4 only received PRN Tylenol three times (7/7, 7/26, and 7/27/16). The back of the MAR did not indicate why the medication was administered, nor the resident's pain level prior to or following pain medication. R4's progress notes from 5/2016 to 8/2016 indicated multiple complaints of groin pain that he rated between 3-9 out of 10 and the resident had requested pain medication. Each progress note was followed up with a note indicating "PRN administration was: Effective," however, the note did not indicate a pain rating prior to or after pain medication. In addition a progress notes revealed R4 was seen by his physician four times: 1) 5/24/16 abdominal binder was to be ordered, 2) 6/7/16 no documenting related to pain or pain management, 3) 7/7/16 orders for unrelated testing, 4) and 7/19/16 no documentation related to pain or pain management was documented. An interview on 8/23/16, at 2:23 p.m. the DON explained R4 was receiving oxycodone when he was initially admitted to the facility, but was so "doped up" it was stopped. The DON went on to explain, "When [R4] first came here a psychologist stated he is a drug seeker for pain medication." The DON explained R4 showed no non-verbal signs of being in pain. "He stays in his room all day, comes down to eat and then goes back upstairs to his room." The DON stated R4 could ask for pain medication if he needed it. She	F 309	of different medication including wanting more oxycontin. His lack of insight into mental illness and medication benefits adds to his desire to end psychotropic plan." "Finds rest in bed a primary comfort." "this lethargy with limited socialization appears chronic with low motivation connected to the persistent mental illness." "Despite his focus on pain there was no grimace or significant nonverbal indicators of discomfort." On 6/11 he was seen by Linda Goldetsky "He transfers all distress to specific groin pain preoccupation." "he wants pain medication for relief." "this apathy/lethargy is a chronic behavioral pattern connected to his	

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F 309	Continued From page 6 also said she had seen the resident finish a meal, but then did not bus his dishes as usual. He had informed a staff person, "I can't. I'm in too much pain. I want oxycodone." The DON verified R4 could have PRN Tylenol and PRN gabapentin in addition to scheduled and she had administered three PRN doses during the month. The DON verified she had not, however, documented relevant information on the back of the MAR. When asked how often staff was expected to ask R4 if he was in pain or needed PRN pain medication related to pain ratings the DON replied, "None--he can come to us." The DON said R4 was aware PRN pain medication was ordered. She was aware R4 rated his pain at around 8 or 9, but said the rating was "subjective." When asked if isolation could have been considered non-verbal signs of pain the DON responded, "I see him in his room alone as being depressed not pain." The DON explained she had attempted to get the resident an abdominal binder, but they came in small, medium and large, and he would need to be measured and a call made to the physician. A follow-up interview on 8/23/16, at 3:07 p.m. R4 was lying on his bed. He again stated he had groin pain that day and "every day between 8 and 9. I have to ask for pain medication and the nurse does not ask me everyday if I have pain or need a pain pill." On 8/24/16 at 8:45 a.m. R4 explained he received pain medication at 8:00 a.m., noon, and 4:00 p.m. He stated, "I just recently found out by the DON that I can get gabapentin if needed...I want to see a new psychologist but the DON said I'm 'doctor shopping.'" R4 explained he did participate in some activities but said "It's painful to get around and do things normally with	F 309	persistent and chronic mental illness. "somatic preoccupation is a set view with inconsistent indicators of pain. Reasoning does not alter this somatic preoccupation." 7/19 he was seen by Dr. William Hoang who states "patient goes into detail about his pain. This has been evaluated in the past and he was not deemed a good candidate for narcotics given he was too disoriented while on them thus psychiatrist have denied this request "Abdominal discomfort which he was experiencing while ambulating at last evaluation has improved from previous. Still interested in getting an abdominal binder." MD visit on 6/7 and 7/7 was psychiatrist, no c/o or changes. Facility has	

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F 309	Continued From page 7 groin pain." He said he was unsure what times he could have his PRN pain medications and did not want to ask for a pain pill and "They think I'm stupid or just seeking pain medication....When I go upstairs they thinks I'm sleeping but I'm just resting because the pain in my groin. It's less painful when I lay down." R4's routine was very similar on all four days of the survey. For example, R4 was observed on 8/24/16, at 9:25 a.m. He went from his room to the common area. He independently listened to music without interacting with others. After midmorning snack was provided R4 left and returned to his room. The same day at 1:06 p.m. R4 stated he came downstairs to get something to eat. He rated his pain as 8 out of 10. On 8/25/16, at 9:27 a.m. R4 was observed in bed listening to music. R4 was again interviewed and stated he felt a tolerable pain level for him would have been 3 out of 10. R4's psychology notes dated 8/5/16, indicated R4 was engaged in more spontaneous dialog and talked about not going to the store with the facility group due to pain. R4's Cornell Scale was 4/38, >12 indicative of depression. Recommendations were that when the resident "complains of pain and/or medication change it is important to acknowledge hearing his expression/opinion." A facility policy and procedure for pain management was requested but not received.	F 309	been consistently addressing R4s pain issues. Again, while Interviewer stated that DON had verified that no documentation existed, the relevant information (below)was indeed charted in R4s progress notes. In progress note on 8/14 it is charted that he is asking for pain meds and he was given gabapentin for 9 out of 10 groin pain - administration was effective. -On 8/18 Gabapentin was requested for back and right groin pain - administration was effective - on 8/19 Gabapentin was requested for groin pain - administration was effective.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	The facility will develop a policy and procedure for the effective pain management by the due	

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F 329	Continued From page 8 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete antipsychotic side effect monitoring for 4 of 5 residents (R9, R20, R12, R18) who were reviewed for unnecessary medications. Findings include: R9 was observed on 8/24/16, at 10:32 a.m. independently walking around the facility and talking to other residents. R9 reported she was unsure what medications she was prescribed.	F 329	date. The DON will be responsible for the development and implementation of the pain management policies.	

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F 329	Continued From page 9 R9 was admitted to the facility in 2005. R9's quarterly Minimum Data Set (MDS) dated 5/14/16, indicated R9 had a diagnoses of Parkinson's disease, anxiety, depression, schizophrenia and was prescribed antipsychotic medications. A review of R9's medication administration records (MAR) indicated R9 was receiving the antipsychotics Clozapine 225 milligrams (mg) at bedtime and Seroquel 25 mg as needed for borderline personality disorder. During an interview on 8/24/16, at 10:20 a.m. the director of nursing (DON) stated she felt R9's antipsychotic medication required more frequent adjusting, and the resident's neurologist and psychologist were working together to adjust them. The DON explained R9 had been re-started on Seroquel but felt she still she continued to experience a lot of extrapyramidal (involuntary movements) side effects. The DON stated, "I see [R9] moving her legs a lot by bouncing them up and down uncontrollably." During an interview on 8/24/16, at 10:14 a.m. the DON stated tardive dyskinesia (TD--irreversible neurological disorder of involuntary movements caused by long-term use of antipsychotic medications) was monitored at the facility using the Dyskinesia Identification System Condensed User Scale (DISCUS). R9's TD monitoring was completed on 3/26/15, which revealed a score of 1 indicating no TD. The DON explained R9 did not have a current DISCUS, but was scheduled to see her physician on 8/26/16. In addition R9's medical record was missing orthostatic blood pressure (OBP)monitoring (sudden drop in blood pressure after a period of rest and with rising/known to be related to	F 329	F329 10-17-16 The antipsychotic side effect monitoring for Residents R9, R20, R12 and R18 will be completed by 10-17-16. There was a completed DISCUS evaluation for one of the indicated residents in her chart at the time of the survey. (A copy is attached to this 2567.) R12s orthostatic blood pressure will be checked regularly as prescribed by the attending physician. The consulting pharmacists documents and recommendations will be kept current and in the facility for the use of all staff and physicians as needed. To ensure that a resident does not receive any unnecessary medication without proper monitoring, indication, dosage or duration and/or in the presence of	

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F 329	Continued From page 10 antipsychotic use) for 5/16. OBPs in 6/16 read 99/68 sitting and 91/63 standing, and 7/16 read 155/93 sitting and 114/75 standing, both showing drops in blood pressure. R20 was admitted admitted to the facility in 2012. A quarterly Minimum Data Set (MDS) dated 8/8/16, indicated diagnoses of bipolar, anxiety, depression and antipsychotic medication use. R20's medication administration records (MAR) indicated she was receiving the antipsychotic Abilify 20 mg at bedtime for bipolar disorder. During an interview on 8/24/16, at 10:14 a.m. the DON stated R20 had a DISCUS completed on 7/23/15 with a score of 7, indicating TD. The DON explained she did not have R20's current DISCUS results, but the resident was scheduled to see her physician the following week. The DON provided copies of all of R20's DISCUS assessments dated 7/23/15 and 6/4/13. In addition, R20's medical record was missing orthostatic blood pressures for 5/16, 6/16, and 7/16. The DON stated she was unsure why OBPs were not taken monthly for all residents prescribed antipsychotic medication. R12 was observed independently walking in the facility on 8/23/16, at 2:20 p.m. and 8/24/16, at 12:59 p.m. A short time later at 1:23 p.m. nursing assistant (NA)-B stated she was trained to ask certain residents how they felt upon rising related to orthostatic blood pressure. Because R12 had issues of jumping out of the chair quickly, she was to ask R12 how he felt upon rising. R12's physician orders dated 6/3/16, indicated: Metoprolol Tartrate 12.5 milligrams (mg) twice	F 329	adverse events, the consultant pharmacist will review the medications of each resident on a monthly basis, making recommendations as indicated. The consultant pharmacist will make recommendations and request documentation/reports of facility staff and prescribers in order to ensure that the resident's need for the medication is obtained and before starting any antipsychotic medication therapy. In addition the consulting pharmacist will regularly request of the prescriber gradual dosage reductions of antipsychotic medications, unless clinically contraindicated. The DON will be responsible for implementing a system	

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F 329	Continued From page 11 daily for atherosclerotic heart disease. Staff was directed to hold the medicine if the resident's heart rate was below 44 or systolic blood pressure below 90. The resident was also prescribed the antipsychotic medication, Invega 234 intramuscularly every 30 days for bipolar depression (start date 1/6/16) and divalproex sodium extended release (anticonvulsant commonly used to alter behavior) 1500 mg at bedtime for bipolar depression (start date 2/4/14). A current DISCUS assessment was not found in R12's chart (although assessments from 7/30/15 and 6/4/13 showed zero TD symptoms). The MARs for R12 revealed OBPs had not been taken in the months of 5/16 and 8/16. Available OBPs showed R12 experienced a drop in systolic and diastolic pressures, which could have contributed to an increased risk for falls. A physician note from a 6/16, physician visit indicated R12 "struggling with Hypotension since his May hospitalization." R12's careplan dated 7/14/16, indicated the resident was at risk for falling due to psychotropic medication use, orthostatic blood pressure and weakness. The care plan noted "Orthostatic blood pressure to be taken monthly and provided to the psychiatrist and MD [physician] at next visit." R12's quarterly MDS dated 6/14/16, indicated R12's cognition was intact, as well as displaying inattention, psychomotor retardation and delusions. On 8/25/16, at 10:34 a.m. DON explained R12 had been hospitalized in 5/16, following a heart attack. R12 was stable with the walker, sometimes had periods of unsteadiness. The resident walked with a slow shuffle and asked	F 329	both for the ongoing timely completion of the DISCUS evaluations of all residents and for the orthostatic blood pressure monitoring of residents requiring monitoring on a monthly basis. The DON will be responsible for monitoring the implementation of these protocols.	

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F 329	Continued From page 12 staff to walk with him. The DON stated R12 also had diagnoses of schizophrenia, bipolar depression and hypotension. On 8/25/16, at 10:55 a.m. the consulting pharmacist (CP) stated he had made some recommendations for R12, one being a gradual medication dose reduction. The CP, however, could not produce his notes from 1/16 to 6/16, as his computer was down. He confirmed DISCUS assessments should have been performed every six months and OBPs should have been taken monthly for all residents who were prescribed antipsychotic medication. On 8/25/16, at 1:02 p.m. DON verified the last DISCUS completed for R12 was 7/30/15. The DON stated the DISCUS was overdue and she was responsible for the assessments to be completed. Since she had started at the facility, she had been "catching up" with past due DISCUS assessments. The plan had been for a nurse to come in that day to complete them, however, she told her not to come in since the survey was in progress. R18 was observed walking to the deck on 8/23/16, at 9:06 a.m. Later that morning at 11:05 the resident was again observed walking using a cane and the hand rail in the hallway. After lunch at 1:35 p.m. R18 was observed walking with walker from dining room into hall. On 8/24/16, R18 was again observed walking to the outside deck on 1:06 p.m. and 1:43 p.m. steady on feet with cane. On 8/23/16, at 1:35 p.m. R18 reported she utilized a walker when she left the facility, and was going on an activity. On 8/24/16, at 1:06 p.m. R18 stated she did not feel faint or dizzy upon rising.	F 329		

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F 329	Continued From page 13 R18's 7/21/15, care plan indicated R18 had impaired cognitive function related to impaired decision making and dementia and need for close supervision. The use of psychotropic medications was noted, and the care plan included interventions for "DISCUS to be completed every per facility policy" and to monitor, document and report any adverse reactions including tardive dyskinesia. Physician orders for R18 indicated an order for the antipsychotics Risperidone 6 mg at bedtime (start date 2/2/16) for bipolar disorder and Abilify 15 mg in the morning schizoaffective disorder (start date 2/3/16). R18's also had physician orders for the antidepressant (commonly used to promote sleep) Trazodone HCL 100 mg at bedtime (start date 2/12/15) as well as hydroxyzine pamoate 25 mg every 4 hours as needed for anxiety or agitation. A quarterly MDS dated 7/21/16, indicated R18's cognition was intact, and the resident required limited assistance of staff with walking when off the unit. On 8/23/16, at 1:42 p.m. NA-B stated R18 had been at risk for falling, but this had not been a current issue. NA-B stated R18 used to be unsteady on her feet, had attended therapy and was now doing "really good." The following morning at 8:32 a.m. DON stated she could not find any consulting pharmacy (CP) notes or recommendations from 2016, but would ask the CP to send a copy. DON stated the CP had reported his computer was down overnight, making it difficult for him to retrieve records, but	F 329		

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	245606	A. BUILDING _____ B. WING _____	08/25/2016

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F 329	Continued From page 14 he would try again that day. The DON stated R18 experienced a lot of delusions, hallucinations and was worried a lot. In addition, R18 was walking much better now after falling frequently in the previous year. After therapy, R18 had advanced from the walker to a cane, but preferred the walker on uneven ground. The DON verified R18's last DISCUS completed was 4/17/15, and was overdue. The DON said OBPs were could have been found on the flow charts that NA-B had, and NAs had been trained to compete the OBPs, which were then read by LPN-B and the DON. DON stated OBPs were to be completed monthly for all residents prescribed psychotropic medications. At 1:23 p.m. on 8/24/16, NA-B stated she was trained to ask certain residents how they felt upon rising when taking the OBPs but this did not include R18. The following morning at 9:01 a.m. NA-B stated she had not yet started the OBPs for the residents for the month of August. NA-B stated the OBPs were typically completed the first week of the month but not always. NA-B verified the OBP flow chart for July and previous months did not indicate the date or time the OBPs were completed. NA-B stated no date or time since the form did not have a column for it as different forms had been used. NA-B stated sometimes the OBPs were completed in the evenings and sometimes on days to vary the times. On 8/25/16, at 9:37 a.m. the DON verified the August 2016 OBPs had not yet been taken for all the residents taking psychotropic medications, stated the day and evening NAs work on it together and verified there was no date or time indicating when the OBPs were not completed for the residents, only the month labeled on the top	F 329		

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F 329	Continued From page 15 of the form as "July." The DON verified May OBPs not have been completed, but thought perhaps they had been completed and were misplaced. In addition, R18's medical record was missing the months of May and June's OBPs and R18's OBP had yet been taken for the month of August. The facility's 1/1/07, Medication Monitoring And Management policy indicated "In order to maintain the resident's highest level of practicable functioning and to prevent and minimize adverse consequences related to medication therapy, the facility establishes monitoring standards for certain medications to promote safe and effective use of the medications...The nursing staff, prescriber, and consultant pharmacist use the standing monitoring orders to assist in assessing appropriateness, effectiveness, and possible adverse consequences of the medications." The facility's 1/1/07 Consultant Pharmacist Reports policy indicated "In performing medication regimen reviews, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards...Resident is monitored for adverse consequences when there is an addition or deletion of a medication, or a change in dose." The facility's 5/15, DISCUS policy indicated "Any resident that is prescribed neuroleptic medication will have a DISCUS completed per the following schedule: Procedure...All residents currently taking a neuroleptic medication shall be assessed at least once every six months or more frequently as necessary by symptom assessment." The same policy also indicated "The consulting	F 329		

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F 329	Continued From page 16 pharmacist and DON will check monthly the DISCUS for each resident receiving a neuroleptic medication."	F 329	F-334 10-17-16 R12 has been seen by his primary physician and the facility recommended that he receive Prevnar13 because he has a new diagnosis of CAD and is eligible to receive this injection. R12 received the Prevnar13 on 9-27-16. A new immunization policy will be implemented by the due date that includes the new recommendations of the CDC. The DON will be responsible for the implementation of this policy.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334		

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F 334	Continued From page 17 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide immunization to minimize the risk for pneumonia according the the Centers for Disease Control (CDC) 2016 guidelines (Prevnar 13) for 1 of 1 resident (R12) who met criteria for immunization.	F 334		

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F 334	Continued From page 18 Findings include: R12's immunization record indicated the resident the resident had not been offered the Prevnar 13 Pneumovax. The CDC's 2016 Recommended Immunizations for Adults: By Health Condition included Prevnar 13 immunization for persons with heart disease. R12 was a 57 year old resident who had diagnoses including diabetes and atherosclerotic heart disease according to the resident's quarterly Minimum Data Set (MDS) dated 6/14/16. The resident experienced a heart attack in 5/16. On 8/25/16, at 9:21 a.m. the director of nursing/infection control nurse (DON) stated she wanted to update the facility's present pneumococcal policy because of new recommendations by the CDC, which she learned about in 3/16, from the facility's administrator. Residents at the facility would receive immunizations at the clinic according to the DON. Although R12 was under 65 years, had had a heart attack in May and now that R12 had heart disease would have required the Prevnar 13 Pneumovax. The DON verified R12 had not been given the Prevnar 13 Pneumovax, nor had it been addressed with R12's physician. She would, however, address the need for vaccination with R12's physician at the time of the resident's next 60 day physician visit. The DON stated she was responsible to ensure the residents received vaccinations. At 1:40 p.m. The DON stated R12 had seen his primary physician after his heart attack and hospitalization (in May) in July and had seen his	F 334		

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F 334	Continued From page 19 cardiologist 2-3 weeks ago, but the Prevnar 13 had not been addressed with either physician. Review of the facility pneumococcal policy did not indicate the Prevnar 13 vaccine to be given to the residents or to be addressed with the residents' physician.	F 334	**F441** **9-30-16** An Infection Control training and information session will be held by 10-21-16 for all relevant staff in order that they may receive instruction on the appropriate method and timing of hand washing. New roller mechanisms for the roller towel dispensers have been installed in an effort to eliminate contamination with touching the toilet/sink. The facility is assessing the appropriateness and effectiveness for paper towel dispensing instead of roller towels. The DON as the Infection Control Nurse is responsible for monitoring the staff's effective adherence to the facility's infection control policies.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		

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F 441	Continued From page 20 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting cares in a sanitary manner for 1 of 3 residents (R11) reviewed for activities of daily living. Findings include: R11 was seated on the side of her bed on 8/24/16, at 8:10 a.m. Nursing assistant (NA)-B was bending over helping R11 put on the resident's shoes and tie them. NA-B then took both R11's hands helped the resident walk to the shower room. NA-B donned gloves, helped R11 pull down her slacks and remove a wet incontinence pad which the NA confirmed was wet. She then threw the pad in the garbage and removed her gloves. Without first cleaning her hands, NA-B donned new gloves, put a clean pad into R11's underpants and reached into the wipes container on top of the back of toilet and removed a couple of wipes. The linen towel hanging from the wall dispenser which had been used and was dirty was hanging down touching the wipes package and the top of the toilet. NA-B cleaned R11's peri area and then threw the wipes in the garbage. Without then removing the soiled gloves, NA-B assisted R11 to pull up her underwear and slacks.	F 441		

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F 441	Continued From page 21 After pulling up R11's slacks NA-B removed the gloves and threw them in the garbage. Then NA-B helped R11 stand up and flushed the toilet. R11 washed her hands and turned the faucet off with her clean hands, and pulled down a clean towel from the linen towel dispenser. NA-B standing nearby turned the faucet on with her hands and washed her hands at the sink, and then turned the faucet off with her bare hands. NA-B pulled down on the linen towel and dried her hands. NA-B then took R11 hands and helped walk R11 to the nurse's station where R11 sat down. At 8:19 a.m. NA-B verified that although she had been trained to use a clean paper towel to shut off the faucet, she had used her bare hands, and paper towels were unavailable in the shower room. NA-B also verified she had not removed the soiled gloves prior to assisting R11 with her clothing or between glove changes. Later, at 1:40 p.m. NA-B stated she had been trained to wash hands between taking off and donning of new gloves but had not followed the training earlier with R11. R11's quarterly Minimum Data Set (MDS) dated 6/15/16, indicated R11 had impaired cognition and needed staff assistance with toileting. The MDS also indicated R11 was unsteady and required hands on assist to steady from sit to stand, walking, changing direction, on/off the toilet and surface to surface transfers. On 8/25/16, at 10:18 a.m. the director of nursing/infection control nurse (DON) stated she had provided handwashing training to the staff at initial orientation and had been planning to include infection control in-service training in	F 441		

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F 441	Continued From page 22 June. The DON expected the staff to put on gloves before providing pericare and remove the dirty gloves following the task and prior to adjusting a resident's clothing. She expected staff to wash their hands and to use their wrist to turn off the faucet. The DON explained that the cloth towels were shortest when the new roll was put in, and then became longer during usage. She was unaware the linen towel was now hanging on the back of the toilet and on top of the wipes used for residents. When she had noticed the towel was too long, she obtained a key to shorten the towel because, "I hate it when it's touching the toilet and it should not do that." The DON stated she did not expect staff to wash hands between glove changes unless they were visibly dirty, as it was unrealistic when the resident was present. The DON explained she had talked at length to the housekeeper about the towels getting too long. In addition, she had asked the supply company who came on Mondays to fix it, as it had just recently gotten "bad." The facility's 1/07, Handwashing policy indicated, "Proper care for washing of hands is vital to the health of residents/staff and visitors so as to reduce the transmission of organisms and ultimately reduce the spread of infection and disease." The policy also indicated, "Use disposable hand towel to turn off faucet." The facility's 7/16, Glove Use policy indicated, "All health care workers...are expected to wear gloves as a protective measure to avoid the spread of infection and disease. Procedure: 1. Gloves must be worn: ...When touching blood, body fluids, mucous membrane, secretions, excretions, and contaminated items or surfaces... 2. Gloves are to be changed between tasks and procedures on	F 441		

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F 441	Continued From page 23 the same resident after contact with blood, sputum, urine, stool, etc. 3. Remove and dispose of gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient. 4. Wash hands between glove changes, task changes or removal for damage."	F 441	F 458 9-26-16 Waiver Most rooms meet the state guidelines for resident room size and the current facility has operated as	
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 square feet of floor space per resident as required in rooms 103, 104, 205, 206, and 207, potentially affecting 11 of 12 residents (R2, R5, R7, R8, R9, R10, R11, R13, R20, R22, R23) who resided in those rooms. Findings include: Resident rooms 103, 104, 205, 206, and 207 did not meet the required 80 square feet per resident for multiple resident bedrooms. The room sizes list was provided by the administrator on 1/15/13, and indicated: Room 103 had 236.56 square feet, 78.85 square feet per resident Room 104 had 230.77 square feet, 76.92 square feet per resident Room 205 had 117.40 square feet, 58.7 square	F 458	a nursing home for over 50 years with no change in the number of residents per room. A waiver renewal will be requested for the approximately nine (9) square feet needed per resident on average in each of these five rooms. (Please see copy of waiver renewal request attached.) Variations are in accordance with the particular need of each resident and will not adversely affect the health or safety of the residents. The room size waiver was disclosed to the residents who occupy the rooms by the Administrator and signed copies are in their charts. The	

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F 458	Continued From page 24 feet per resident Room 206 had 138.96 square feet, 69.48 square feet per resident Room 207 had 145.44 square feet, 72.72 square feet per resident The rooms were observed to pose no safety hazards and were furnished adequately. There was no evidence these residents were negatively impacted by their room size. The residents had been informed of the room size prior to admission and offered no complaints regarding their rooms during the survey. On 8/22/16, at 12:30 p.m. during the entrance conference, the director of nursing verified the above findings, and stated the facility had previously requested a waiver for the requirement.	F 458	Administrator presents the room size disclosure to future residents in the Admission Agreement.	

Lake Minnetonka Care Center

September 26, 2016

Ms. Gayle Lantto
Unit Supervisor
Licensing and Certification Section
Division of Compliance Monitoring
Minnesota Department of Health
PO Box 64900
St. Paul, MN 55164-0900

RE: Request for Waiver Renewal for:
- F458 SS-B - 483.70(d)(1)(ii) - Requirement: Physical Environment

Dear Ms. Lantto:

We are requesting a waiver renewal for this requirement. While most rooms meet the state guidelines for resident room size and the current facility has operated as a nursing home for over 50 years with no change in the number of residents per room, a waiver is requested for the approximately nine (9) square feet needed per resident on average in each of five rooms. The rooms size does not impede the residents ability to move freely.

The Surveyors 8/22/16 notes indicate on page 25, "The rooms were observed to pose no safety hazards and were furnished adequately. There was no evidence these residents were negatively impacted by their room size. The residents had been informed of the room size prior to admission and offered no complaints regarding their rooms during the survey."

The room size waiver was disclosed to the residents who occupy the rooms by the Administrator and signed copies are in their charts. The Administrator presents the room size disclosure to future residents in the Admission Agreement.

We ask that you favorably consider this request, allowing for the variation of room size.

Thank you for your prompt consideration of our request.

Sincerely,

Jeff Sprinkel
Administrator

20395 Summerville Road Deephaven, MN 55331-9226
Tel. 952-474-4474 Fax. 952-474-4272

F5606024

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 23, 2016. At the time of this survey, Lake Minnetonka Care Center, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 19 Existing Health Care.. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	**APPROVED** [signature] **By Tom Linhoff at 3:10 pm, Sep 26, 2016** RECEIVED SEP 26 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9-26-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Minnetonka Care Center is a 2-story building with a partial basement. The building was constructed in 1920 and was determined to be of Type V(000) Construction. In 1960 an addition was constructed to the north and was determined to be of Type V(000). It is automatic fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. The facility has a capacity of 21 beds with a census of 19 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a)is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012	K 012 10-26-16 To address the K12 Construction Type of Health Care Facilities, a FSES will be completed on the facility by October 26, 2016. Since there were no changes to the building and an FSES was completed last year on the building, it is expected that once again a Two Story Building of Type V (000) construction with an automatic sprinkler system will meet or exceed the equivalency requirements for the facility. All previous FSESs that have been conducted have verified that the facility has been in compliance with the equivalency standards. There have been no alterations, changes or modifications to the building since the last FSES was completed. The administrator will be responsible for ensuring the FSES has been completed.	

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K 012	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirement for construction type and height. This deficient practice could affect all 19 residents. Findings include: On a facility tour between the hours of 09:30 AM and 12:30 PM on August 23, 2016, observation revealed that this 2-story, wood frame facility of Type V(000) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the Administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012	K039 10-26-16 To address the K12 Construction Type of Health Care Facilities, a FSES will be completed on the facility by October 26, 2016. Since there were no changes to the building and an FSES was completed last year on the building, it is expected that once again a Two Story Building of Type V (000) construction with an automatic sprinkler system will meet or exceed the equivalency requirements for the facility. All previous FSESs that have been conducted have verified that the facility has been in compliance with the equivalency standards. There have been no alterations, changes or modifications to the building since the last FSES was completed. The administrator will be responsible for ensuring the FSES has been completed.	
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all 19 residents. Findings include: During a tour of the facility between the hours of	K 039		

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K 039	Continued From page 3 09:30 AM and 12:30 PM on August 23, 2016, observation revealed that portions of the first floor corridor are only 35" wide. This deficient practice was verified by the Administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 039	K 052 8-26-16 The annual alarm panel inspection was scheduled for and completed on August 26, 2016, within 30 days of the due date of the previous annual inspection of July 31, 2015. The administrator is responsible for ensuring that the annual inspection of the alarm panel is completed in a timely manner.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility's fire alarm system maintenance is not being conducted in accordance with NFPA 72, (99). This deficient practice could affect all 19 residents. Findings include: On a facility tour between the hours of 09:30 AM and 12:30 PM on August 23, 2016, observation revealed that the annual fire alarm inspection is past due. The last annual inspection was conducted on 07/31/2015.	K 052	K054 9-8-16 On 9-8-16 all smoke detectors within the facility were replaced with new smoke detectors having the capability of being tested annually for smoke sensitivity. The new smoke detectors have documentation of their having been tested upon installation and are capable of being tested for sensitivity compliance. Documentation of the the smoke detectors annual sensitivity testing will be the responsibility of the administrator.	

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K 052	Continued From page 4 This deficient practice was verified by the Administrator at the time of the inspection.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been documenting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 19 residents. Findings include: On a facility tour between the hours of 09:30 AM and 12:30 PM on August 23, 2016, observation revealed that the facility could not provide documentation for a current smoke detector sensitivity test. The last test was conducted on 08/02/2011. This deficient practice was verified by the Administrator at the time of inspection.	K 054	K064 9-26-16 All of the facility's fire extinguishers had their monthly documentation of maintenance current and in accordance with NFPA 101-2000, except the one extinguisher in the basement, the furthest from patient rooms. This extinguisher was found to be clearly operable and maintained within the NFPA guidelines. The Administrator has notified the person in charge of fire extinguisher inspections of this extinguisher. The administrator is responsible for overseeing the inspection of the extinguishers on a monthly basis.	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10, 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed	K 064		

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K 064	Continued From page 5 to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition and NFPA 10. This deficient practice could affect all 19 residents. Findings include: On a facility tour between the hours of 9:30 AM and 12:30 PM on August 23, 2016, observation revealed that monthly portable fire extinguisher inspections were not being documented. This deficient condition was verified by the Administrator at the time of inspection.	K 064		