DEPARTMENT OF HEA		RVICES DICARE/MEDICA	AID CERTIFIC	ATION A	ND TRAN			MEDICARE & M	EDICAID SE ID: ZR82	RVICES
	PAR	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGE	NCY		Facility ID: 0	0271
<ol> <li>MEDICARE/MEDICAID PRO (L1) 245210</li> </ol>	VIDER NO.	3. NAME AND AD (L3) LAKE M			DEC			4. TYPE OF ACT	<u></u>	
2. STATE VENDOR OR MEDICA	ATD NO	(L4) 4527 SH						1. Initial		tification
(L2) 172043100		(L5) PARK, M		MIVE .		(L6)	55384	3. Termination 5. Validation	4. CHO 6. Comp	
EFFECTIVE DATE CHANCI	OF OUD IT DE LIUD	Conservation and the second			02	200220	33304	7. On-Site Visit	9. Other	
<ol> <li>5. EFFECTIVE DATE CHANGE (L9) 06/03/2010</li> </ol>	OFOWNERSHIP	7. PROVIDER/SUI 01 Hospital	05 HHA	9 ESRD	13 PTIP	(L7)	22 CLIA	8. Full Survey Af	ter Complaint	
6. DATE OF SURVEY	07/28/2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF					
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC			FISCAL YEAR ENI	DING DATE:	(L35)
	1 TJC 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPI	ICE		09/30		
11. LTC PERIOD OF CERTIFIC	ATION	10.THE FACILITY	IS CERTIFIED AS:							
From (a):		X A. In Complian	ace With		100			Following Requiremen	ts:	
To (b) :		Program Re					cal Personnel	6. Scope of		
12. Total Facility Beds	145 (L18)	Compliance	Acceptable POC			24 Hou 7-Day I	ır RN RN (Rural SNF)	7. Medical . 8. Patient R		
12. Iolai Facility Deus	145 (210)		acceptable POC				fety Code	9. Beds/Ro		
13. Total Certified Beds	145 <sup>(L17)</sup>		pliance with Program ents and/or Applied '		* Code:	А	*	(L12)		
14. LTC CERTIFIED BED BREA	KDOWN				15. FACILIT	TY MEE	TS			
18 SNF 18	19 SNF 19 SNF	ICF	E		1861 (e) (	(1) or 186	61 (j) (1):	(L15)		
	145									
(L37)	(L38) (L39)	(L42)	(L43)							
	raceast condition		10000 A							
16. STATE SURVEY AGENCY 1	REMARKS (IF APPLICABLE :	SHOW LTC CANCELL	ATION DATE):							
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVE	Y AGENCY AP	PROVAL	Date:	
Holly Kran	z, HFE NE II		08/21/2014	(L19)	Kate J	ohns	Ton, Enfo	orcementSpeci	alist 09	0/22//201 a
	PART II - TO	BE COMPLETE	D BY HCFA RI		OFFICE	OR SE	NGLE STAT	E AGENCY		(1
19. DETERMINATION OF ELI	GIBILITY		IPLIANCE WITH C	IVIL	21.			ial Solvency (HCFA-257		
1. Facility is Elig	ible to Participate	RIGH	HTS ACT:				nership/Control 1 h of the Above :	Interest Disclosure Stmt (	HCFA-1513)	
2. Facility is not										
	(L21)									
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	INT	26. TERM	INATIO	NACTION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	VOLUNTA	RY	00	INVO	UNTARY	
01/01/1977					01-Merger,	Closure		05-Fail	to Meet Health/Sa	afety
(L24)	(L41)		(L25)		02-Dissatist	faction W	V/ Reimburseme	nt 06-Fail	to Meet Agreeme	nt
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of I	Involuntar	ry Termination	OTHE	R.	
	A. Suspension				04-Other Re	eason for	Withdrawal		vider Status Chan	ge
			(L44)					00-Act	ive	
(	L27) B. Rescind Su	pension Date:								
			(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAI	RKS				
		00320								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	3:	2. DETERMINATION (	OF APPROVAL DA	TE						
	(L32)			(L33)	DETERN	INAT	ION APPRO	VAL		
				(L33)	DETERN	MINAT:	ION APPRO	VAL		00
FORM CMS-1539 (7-84) (Destroy	Prior Editions)									



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245210 Delivered electronically September 25, 2014

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

Dear Mr. Lahammer:

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

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

Effective July 31, 2014 the above facility is recommended for:

145 Skilled Nursing Facility/Nursing Facility Beds

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

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 and 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.

Please contact me if you have any questions.

Lake Minnetonka Shores September 19, 2014 Page 2

Sincerely,

Yole Compton

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

September 25, 2014

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

**RE:** Project Number

Dear Mr. Lahammer:

# It has come to my attention that the survey information, including the effective date, sent to you August 21, 2014 has changed. Please find enclosed a revised Certification Letter and 948 Letter. This letter replaces the letter dated August 21st, 2014.

On June 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2014. 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 July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 4, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014, effective July 31, 2014 and therefore remedies outlined in our letter to you dated June 18, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Inston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 21, 2014

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

RE: Project Number S5210023

Dear Mr. Lahammer:

On June 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2014. 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 July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 4, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014, effective July 11, 2014 and therefore remedies outlined in our letter to you dated June 18, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

ate Comston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245210	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/28/2014
Name	of Facility		Street Address, City, State, Zip Code	
LA	KE MINNETONKA SHORES		4527 SHORELINE DRIVE	
			SPRING PARK, MN 55384	

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

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5	) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 06/27/2014	ID Prefix		Correction Completed 07/11/2014			Correction Completed
Reg. # LSC	483.10(g)(1)	-	Reg. #	483.60(b), (d), (e)	_	Reg. #		
		-			_			
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		_	ID Prefix		
Reg. #		_	Reg. #		_	Reg. #		
LSC		-	LSC		_	LSC _		
		Correction			Correction			Comodian
		Correction Completed			Correction Completed			Correction Completed
ID Prefix			ID Prefix			ID Prefix		
Reg. #			Reg. #					
LSC			LSC		_	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #					
LSC		-			_	LSC		
		-						
		Correction			Correction			Correction
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		-			_			
Reg. # LSC		-	Reg. # LSC		_	Reg. #		
		-						
Reviewed By	Reviewed	Ву	Date:	Signature of Surv	veyor:		Date:	
State Agency	, JS	S/KJ	08/21/201	4	3356	51	07	/28/2014
Reviewed By	Reviewed	Ву	Date:	Signature of Surv	veyor:		Date:	
CMS RO								
Followup to	Survey Completed on:			Check for an	y Uncorrected	Deficiencies. Was a	Summary of	
	6/12/2014			Uncorrect	ed Deficiencies	s (CMS-2567) Sent to	o the Facility? YES	NO

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245210	(Y2) Multiple Constructi A. Building B. Wing	I BUILDING 01	(Y3) Date of Revisit 8/4/2014
Name of Facility			Street Address, City, State, Zip Code	
LA	KE MINNETONKA SHORES		4527 SHORELINE DRIVE	
			SPRING PARK, MN 55384	

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

(Y4) Item		(Y5)	Date	(Y4)	ltem	(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction				Correction					Correction
ID Drofiv			Completed 07/31/2014		ID Drofiv		Completed		ID Drofiv			Completed
			07/31/2014									
-	NFPA 101 K0072				Reg. #				Reg. #			
	10072								200			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix				ID Prefix			
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LSC					LSC				LSC			
			Correction				Corrotion					Correction
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ID Prefix			Completed		ID Prefix				ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC		-		LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix	:		e empleted		ID Prefix				ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			_
Reviewed B	y Re	eviewed B	<sup>b</sup> y	Da	te:	Signature of Surve	yor:				Date:	
State Agence	;y	JS/	/KJ	08	/21/2014		2812	0			08/	04/2014
Reviewed B	y R	eviewed B	3y	Da	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Complete	d on:				Check for any				•		
	6/10/20	14				Uncorrecte	d Deficiencies	s (CMS	-2567) Sent t	o the Facility?	YES	NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL TE SURVEY AGENCY				ID: ZR82 Facility ID: 00271		
I. MEDICARE/MEDICAID PROVIDER N           (L1)         245210           2.STATE VENDOR OR MEDICAID NO.         (L2)           172043100         172043100	чЮ.	3. NAME AND ADI (L3) LAKE M (L4) 4527 SHC (L5) SPRING	INNETONK DRELINE D	A SHO				1. Initia 3. Term 5. Valid	ination ation	<u>2(</u> L8) 2. Recertification 4. CHOW 6. Complaint	
<ol> <li>5. EFFECTIVE DATE CHANGE OF OW (L9) 06/03/2010</li> </ol>	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		9. Other mplaint	
6. DATE OF SURVEY 06/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>12/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI				FISCAL YEAR ENDING DATE: (L35) 09/30		
<ul> <li>11. LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> </ul>	145 (L18) 145 (L17)	10.THE FACILITY I X A. In Complian Program Rec Compliance 1. A B. Not in Comp X Requireme	And/Or Approved Waivers Of The Following Requirements:        2. Technical Personnel      6. Scope of Services Limit        3. 24 Hour RN      7. Medical Director        4. 7-Day RN (Rural SNF)      8. Patient Room Size        5. Life Safety Code      9. Beds/Room         * Code:       B*       (L12)					or			
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILI 1861 (e) (				(L15)		
(L37) (L38)	(L39)	(L42)	(L43)				0, ( ).				
16. STATE SURVEY AGENCY REMARI	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):								
17. SURVEYOR SIGNATURE	Nord, HFE N	Date :	E II 07/01/2014 Kate JohnsTon, E					Specialis	Date: t08/25/2014		
	PART II - TO	BE COMPLETEI	D BY HCFA RE	(L19) GIONAI	LOFFICE	OR SIN	NGLE STA	TE AGENCY	7	(L20)	
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Pai        2. Facility is not Eligible			PLIANCE WITH CI ITS ACT:	VIL	21.	2. Owr		ncial Solvency (H0 I Interest Disclosu :		-1513)	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMEN	NT	26. TERM	MINATIO	N ACTION:		(I	_30)	
OF PARTICIPATION <b>01/01/1977</b>	BEGINNING	DATE	ENDING DATE		<u>VOLUNTA</u> 01-Merger,	Closure		<u>00</u>	INVOLUNT. 05-Fail to Me	<u>ARY</u> eet Health/Safety	
(L24)	(L41)		(L25)				// Reimbursem ry Termination			eet Agreement	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV	of Admissions:	(L44)		04-Other Re				OTHER 07-Provider S 00-Active	Status Change	
(227)	B. Rescind Sus	pension Date:	(L45)								
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMA	RKS					
		00320									
	(L28)			(L31)							
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	E	-						
	(L32)			(L33)	DETERN	MINATI	ION APPRO	OVAL			



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 2250 0001 6356 5125

June 18, 2014

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

RE: Project Number S5210023 and Complaint Number H5210044

Dear Mr. Lahammer:

On June 12, 2014, 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. In addition, at the time of the June 12, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5210044.

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. In addition, at the time of the June 12, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5210044 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor Minnesota Department of Health Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320) 223-7343 Fax: (320) 223-7348

#### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 22, 2014, 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 July 22, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (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;

Lake Minnetonka Shores June 18, 2014 Page 3

- 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

Lake Minnetonka Shores June 18, 2014 Page 4 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 September 12, 2014 (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 December 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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.

Lake Minnetonka Shores June 18, 2014 Page 5

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

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

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Are Kleggere.

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	IPLE CONSTRUCTION JUN 3 0 2014	(3) DATE SURVEY COMPLETED
		245210	B. WING _	MN Dept of Health	C 06/12/2014
	PROVIDER OR SUPPLIER	;		STREET ADDRESS, CITY, STASE CARLODE 4527 SHORELINE DRIVE SPRING PARK, MN 55384	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000 F 167 SS=C	as your allegation of Department's accept bottom of the first properties accept be used as verificat Upon receipt of an revisit of your facilit validate that substar regulations has beer your verification. A standard recertific and a complaint invi- completed at the tim investigation of com- been substantiated 483.10(g)(1) RIGHT READILY ACCESS A resident has the re- the most recent sur- Federal or State su- correction in effect. The facility must ma- examination and m- accessible to resid their availability.	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with cation survey was conducted restigation had also been ne of the standard survey. An nplaint H5210044 had not during this survey. T TO SURVEY RESULTS -	F 00	This plan and response to the survey findings is written so to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement nor an agreem with any finding. We wish preserve our right to disput these findings in their entire at any time and in any legal action. We may submit a	lely the e ent to e ety al
	review, the facility fa	ion, interview, and document ailed to ensure the most ay results were posted in a		ninger	

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.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PRINTED: 06/18/2014 FORM APPROVED OMB\_NO: 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			(	<u> DMB NO.</u>	0938-039
	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		· ·	TIPLE CONSTRI		Сом	E SURVEY PLETED
		245210	B. WING			4	C 12/2014
NAME OF I	PROVIDER OR SUPPLIER	J	· ]	STREET ADD	RESS, CITY, STATE, ZIP CODE		
LAKE MI	NNETONKA SHORE	S			ELINE DRIVE ARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 167	place which was vi all residents to revi effect all 134 reside family, and visitors Findings include: During the initial to 1:15 p.m., the fede indicating where to able to be located. During observation plastic bin was loca medication room a forms" on the third concern forms was protective sheath t are available outsid dining room." During observation unlabeled plastic b elevator on the sec forms were inside of label indicating what the quality concern unlabeled protective that noted "The Su outside TCU dining During observation was an unlabeled p TCU dining room of bin was empty.	sible and readily accessible for iew. This had the potential to ents residing in the facility, ur of the facility on 6/9/14, at eral survey results, nor a sign of find the survey results, were a on 6/9/14, at 3:10 p.m. a ated across from the nd labeled "quality concern floor. Behind the quality is a sheet of paper inside a hat noted "The Survey results de TCU (transitional care unit) a on 6/9/14, at 3:20 p.m. an in was located across from the cond floor. Quality concern of the bin and there was no at the bin contained. Behind a forms, which was in the re sheath, was a sheet of paper rvey results are available g room." a on 6/9/14, at 3:30 p.m. there plastic bin located outside the on the first floor, however, the	F 1	F 176 (	to other residents: At the scheduled Resident Council/Family Council survey results and locatio from 2014 will be discuss with resident and family. will be documented in the notes from the meeting. Posters are displayed on a floors as to where to find Survey Results. The Sur Book is displayed outside the TCU Dining Room w many residents travel by activities are held.	TCU ere inted floors he inder. pplies e next the on sed This e all the vey e of chere and	
	binder was located	n on 6/10/14, at 9:07 a.m., a I in the top drawer outside the on first floor, directly across					6/27/

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

Event ID: ZR8211

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

PRINTED: 06/18/2014 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245210	B. WING		A REAL PROPERTY OF A REAL PROPER	C / <b>12/2014</b>
NAME OF	PROVIDER OR SUPPLIER		ſ	STREET ADDRESS, CITY, STATE, Z	IP CODE	
LAKE M	NNETONKA SHORES			4527 SHORELINE DRIVE SPRING PARK, MN 55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLETIO DATE
F 167	labeled 2013 surver closed, and there w survey results were During interview on member (F)-B state location of the surver During interview on stated she was not survey results. During tour on 6/10 administrator stated have been posted of but were not. The a difficult to find the s which were in the p residents or family to results were posted During interview on (who was the secre council), stated the was held on March unaware of where to posted, does not re the meeting, and th them on a staff men to see them. During interview on stated she attended and could not recal being discussed at "interested to know	The outside of the binder was y results. The drawer was vas no sign indicating the located in the drawer. 6/9/14, at 6:41 p.m. family ed she was not aware of the ey results. 6/10/14, at 9:40 a.m. F-A aware of the location of the /14, at 11:23 a.m., the d the survey results should butside the TCU dining room administrator verified it was urvey results, and the signs lastic bins did not direct to where the current survey	F 1	prevented by: Au done 1x weekly b assigned Househo Coordinator on Ea check for the post residents/family w Survey Results an The Household C for TCU will audi for proper placem results outside the Room. Household Coordinators will family or resident make sure they ar the location of the Results. The 3 Ri will be updated to results including a Surveys, follow u reports, and along approved plans of noted deficiencies Administrator or 5. The Correction w monitored by:	adits will be y the ld ach Floor to er alerting where the e located. oordinator it 1x weekly ent of the e TCU Dining d interview 3 s weekly to e aware of e Survey ing Binder o Survey any extended p visit g with state f correction of s by the designee. will be ill be given to rator for or will report QA Team.	

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

Facility ID: 00271

If continuation sheet Page 3 of 7

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

PRINTED: 06/18/2014 FORM APPROVED OMB NO 0938-0391

	AS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			СОМ	E SURVEY PLETED
		245210	B. WING	i			C 1 <b>2/2014</b>
	PROVIDER OR SUPPLIER	;		452	REET ADDRESS, CITY, STATE, ZIP CODE 27 SHORELINE DRIVE IRING PARK, MN 55384	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167 F 431 SS=E	council meeting min previous 11 months the survey results a access to them was The Facility policy t Results created 11/ most recent standa subsequent extend reports, etc., along of correction of note in a 3 ring binder or frequented by most lobby or activity are 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biologica labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a	6 a.m., the facility resident nutes were reviewed for the and there was no evidence and the resident's right to have s reviewed with the resident's. itled Examination of Survey 2003, noted a copy of the rd survey, including any ed surveys, follow-up revisit with the state-approved plans ad deficiencies, is maintained folder located in an area residents, such as the main a. DRUG RECORDS, UGS & BIOLOGICALS mploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the	F 1	167	<ul> <li>F431</li> <li>Corrective Action: The opened or expired meds wer immediately removed from med room and the inhaler frithe med cart.</li> <li>Correction Action as it applito others: An immediate review was completed of all med carts/med rooms to ensino other like meds were available to residents. An in service will be scheduled fo the week 7/7/2014 for Nurse/TMA regarding prop storage medication includin labeling and open dates. In service will include which medication are in need of destruction related to dates opened.</li> <li>Date of Completion:</li> </ul>	e the om ies ure 1- r g	
		t only authorized personnel to			7/11/2014		

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

Facility ID: 00271

If continuation sheet Page 4 of 7

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING С B. WING 245210 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4527 SHORELINE DRIVE** LAKE MINNETONKA SHORES SPRING PARK, MN 55384 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 4 F 431 F 431 4. Reoccurrence will be have access to the keys. prevented by: The Clinical The facility must provide separately locked, Coordinator or designee will permanently affixed compartments for storage of audit medication storage areas controlled drugs listed in Schedule II of the weekly for compliance by Comprehensive Drug Abuse Prevention and visually inspecting medication Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit storage areas reviewing package drug distribution systems in which the outdated meds and opened quantity stored is minimal and a missing dose can meds in need of destruction. be readily detected. The staff will have an inservice regarding proper storage/labeling of medication This REQUIREMENT is not met as evidenced for resident use. Merwin by: Pharmacy will be involved Based on observation, interview, and record review the facility failed to establish a system to with quarterly review of med ensure stock supply of expired medications were pass and storage. removed to prevent further resident use and failed to ensure medications which had been The Correction will be 5 opened were dated to ensure they were not used monitored by: after expiration, for 1 of 3 medication storage The audits will be given rooms, where expired medications remained a. available for use and contained opened and to the Clinical unlabeled medication. This had the potential to Administrator for review. affect all 29 residents that currently resided on b. The Clinical the Transitional Care Unit. In addition, the facility Administrator will failed to ensure proper labeling of inhalers for 1 of present to QA Team to 1 residents, (R115) who used an inhaler which review. OA will was not labeled. determine frequency of audits. Findings include: The Clinical C. Administrator will be During an observation on 6/12/14, at 2:17 p.m., responsible for the medication storage room refrigerator on the compliance. 1st floor Transition Care Unit (TCU), contained a box of Biscolax 10 mg suppositories (rectal medication used to stimulate bowels) which Facility ID: 00271 If continuation sheet Page 5 of 7 Event ID: ZR8211 FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 06/18/2014

CENTERS FOR MEDICARE & MEDICARD SERVICES     DMB NO. 0938-0391       INTERMENT OF INFORMENCE (M)     (M) PROVEMENCE (M)     (M) DATE SURVEY       AND FLAN OF CORRECTION     (M) DENTIFICATION NUMBER:     (M) DATE SURVEY       245210     E. WIND     STREET ADDRESS, CITY, STATE, ZIP CODE       ARE OF PROVIDEN ON SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     (G) 0612/2014       ARE OF PROVIDEN ON STATE PARCEDOR DEVILUE     PROVIDENT ON OF CONFECTION     (G) 0612/2014       PRETIX     EACH DERICENON MUST RE PRECEDOR DEVILUE     PROVIDENT ON OF CONFECTION     (G) 0604/2014       PRETIX     EACH DERICENON MUST RE PRECEDOR DEVILUE     PRETIX     (G) 0604/2014       PRETIX     EACH DERICENON MUST RE PRECEDOR DEVILUE     PRETIX     (G) 0604/2014       PRETIX     EACH DERICENON MUST RE PRECEDOR DEVILUE     PRETIX     (G) 0604/2014       PRETIX     EACH DERICENON MUST RE PRECEDOR DEVILUE     PRETIX     (G) 0604/2014       F 431     Continued From page 5     F 431     (G) 0604/2014     (G) 0604/2014       I use and the other was dispensed in APRIC DOLE     F 431     (G) 0604/2014     (G) 0604/2014       I use and the other was dispensed in APRIC DOLE     F 431     (G) 0604/2014     (G) 0604/2014       I use an observation on fifth and the od abord     (G) 0604/2014     (G) 0604/2014     (G) 0604/2014       I use an observation on	DEPARTMENT OF H							FORM A	06/18/2014 PPROVED
24210         R. WNG         06/12/2014           NME OF PHOYDER OR SUPPLER         STREET ADDRESS. CITY. STATE, 2P CODE 427 SHORELINE DRIVE SPRIND PARK, MN 55384         STREET ADDRESS. CITY. STATE, 2P CODE 427 SHORELINE DRIVE SPRIND PARK, MN 55384           MAIL OF PHOYNCR IS DENTIFYING INCIDES TAG         SUMMAY SIATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRICEDED BY ULL TAG         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL SPRIND PARK, MN 55384         D         Could a control (EACH DEPICIENCY MUST BE PRICEDED BY ULL TAG         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL BEROLEDON         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL TAG         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL BEROLEDON         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL TAG         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL BEROLEDON         D         PHOYNCR IS CORRECTION. PLACE DEPICIENCY MUST BE PRICEDED BY ULL TAG         D         PHOYNCR IS CORRECTION. PLACE DEPICENCY MUST BE PRICEDED BY ULL TAG         D         PHOYNCR IS CORRECTION. PLACE DEPICENCY DETECTION. PLACE DEPICENCY INTERS HERE DEPICED BY ULL TAG         D	STATEMENT OF DEFICIENC	IES	(X1) PROVIDER/S	SUPPLIER/CLIA				(X3) DATE COMPI	SURVEY
LAKE MINNETONKA SHORES     4527 SHORELINE DRIVE SPRING PARK, MN 55384       CMU TO PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE OF LOC DENTIFYING INFORMATION)     D PREFIX TAG     D			24	5210	B. WING _				2/2014
LAKE MINNETONKASHORES     SPRING PARK, MN 56384       [X4] ID PHEFK TAG     SUMARY STATEMENT OF DEFICIENCIES (EAC) ESCIENCY MUST BE FIRECUED BY FULL RECULATORY OF LISC DEMINFYING INFORMATION)     ID PROVIDERS TANDOF CONFECTION (EAC) CONFICTING AFCOMATION (EAC) CONFICTING AFCOMATION)     PROVIDERS TANDOF CONFECTION (EAC) CONFICTING AFCOMATION (EAC) CONFICTING AFCOMATION)     ID PROVIDERS TANDOF CONFECTION (EAC) CONFICTING AFCOMATION)     ID PROVIDERS TANDOF (EAC) CONFICTING (EAC) CONFICTING AFCOMATION)     ID PROVIDERS TANDOF (EAC) CONFICTING (EAC) CONFICTING AFCOMATION)     ID PROVIDERS TANDOF (EAC) CONFECTING (EAC) CONFICTING AFCOMATION)     ID PROVIDERS TANDOF (EAC) CONFICTING AFCOMATION (EAC) CONFICTING AFCOMATION)     ID PROVIDERS TANDOF (EAC) CONFICTING (EAC) CONFICTING AFCOMATION (EAC) CONFICTING AFCOMATION (EAC) CONFICTING (EAC) CONFICTING AFCOMATION (EAC) CONFICTING (EAC) CONFICTING (EAC	NAME OF PROVIDER OR S	UPPLIER		·····					
PREFX TVG       CEACH CORRECTVE ACTION HOLLO BE BEQUATORY OF LSC IDENTIFYING INFORMATION)       PREFX TVG       CEACH CORRECTVE ACTION HOLLO BE CROSS-REFERENCE TO THE APPROPRIATE       Deficiency Mutter DEFICIENCY         F 431       Continued From page 5 expired on 4/14. Clinical coordinator (CC)-A was well as new admissions. The TOU refrigerator contained two butles of multicose Applied 5 tuberculin units/ 0.1 ml (injectable medication to detect tuberculosis infection) which were opened but not dated. CC-A verified the bottles were "not dated" with the date opened. One bottle was dispensed from the pharmacy in March, 2014, and the othor was dispensed in April, 2014. CC-A stated Applicol is used for all new admissions to the TCU. CC-A referenced the facility's "Medication Storage and Expiration Guidelines" from Merwin Long Term Care Pharmacy, dated 09/2008, and verified tuberculu injection vials should be discarded '30 days after the 1st Use."         A review of the UHP Pharmaceuticals package instructions for the storage of Applicol included, "Vials in use more than 30 days should be discarded due to poesculic optency."         The facility's Standing Orders for Transitional Care, undated, included or May have Duicolax or glycerin suppository' every three days as needed.         During an observation on 6/12/14, at 11:30 a.m., the 2 West medication car contained two Acvair 250/50 inhalers in a compartment labeled with RT15's name. Neither of the inhalers had a handwritten date of 51/16/14. Trained medication assistant (TMA)- was present during the observation and verified the inhalers did not have		SHORES	6						
expired on 4/14. Clinical coordinator (CC)-A was present at the time of observation and verified the product was expliced, but remained available for use, and it was included on the TCU's standing orders for all residents currently in the unit, as well as new admissions. The TCU refrigerator contained two bottles of multidose Aplisol 5 tuberculin units/0.1 ml (injectable medication to detect tuberculosis infection) which were opened but not dated. CC-A verified the bottles were "not dated" with the date opened. One bottle was dispensed from the pharmacy in March, 2014, and the other was dispensed in April, 2014. CC-A stated Aplisol is used for all new admissions to the TCU. CC-A referenced the facility's "Medication Storage and Expiration Guidelines" from Merwin Long Term Care Pharmacy, dated 00/2008, and verified tuberculin injection vials should be discarded "30 days after the 1st Use." A review of the JHP Pharmaceuticals package instructions for the storage of Aplisol included, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The facility's Standing Orders for Transitional Care, undated, included "May have Duicolax or glycerin suppository" every three days as needed. During an observation on 6/12/14, at 11:30 a.m., the 2 West medication cart contained two Advair 250/50 inhalers in a compartment labeled with R115's name. Neither of the inhalers had a pharmacy label which indicated for whom the inhalers were prescribed. One of the inhalers had a handwritten date of 5/16/14. Trained medication assistint (TMA). A was present during the observation and verified the inhalers had a handwritten date of 5/16/14. Trained medication assistint (TMA). A was present during the observation and verified the inhalers did not have	PREFIX (EACH D	EFICIENC	Y MUST BE PRECEI	DED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD CED TO THE APPROPE	BE	COMPLETION
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZR8211 Facility ID: 00271 If continuation sheet Page 6 of 7	expired on present at t product wa use, and it orders for a well as new contained t tuberculin u detect tube but not date dated" with dispensed t and the oth stated Aplis the TCU. O "Medication from Merwi 09/2008, ar should be o A review of instructions "Vials in us discarded o degradation The facility' Care, unda glycerin sup During an o the 2 West 250/50 inha R115's nam pharmacy li inhalers we a handwritt assistant (T	4/14. CI he time s expire was incl all reside v admiss wo bottl inits/ 0.1 rculosis ed. CC- the date from the er was of col is use CC-A ref b Storag n Long n Long n Long n Long n Long the JHF for the e more the due to po n which s Stand ted, incl positor observat medica alers in a ne. Neith abel which	inical coordinat of observation d, but remained uded on the TC onts currently in- sions. The TCL es of multidose ml (injectable infection) whic A verified the b e opened. One pharmacy in M dispensed in Ap ed for all new a erenced the face e and Expiratio Term Care Pha ed tuberculin in d "30 days afte Pharmaceutic storage of Aplis than 30 days sl ossible oxidatio may affect pote ing Orders for uded "May hav y" every three co- ion on 6/12/14, tion cart contain a compartment her of the inhale ch indicated fo cribed. One of to of 5/16/14. Tra was present du rified the inhale	and verified the d available for CU's standing the unit, as J refrigerator Aplisol 5 medication to h were opened bottles were "not bottles were "not bottle was March, 2014, oril, 2014. CC-A dmissions to cility's on Guidelines" armacy, dated jection vials or the 1st Use." Cals package sol included, hould be on and ency." Transitional the Dulcolax or days as needed. at 11:30 a.m., ned two Advair labeled with ers had a r whom the the inhalers had ined medication ring the ers did not have			faction		Page 6 of

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

PRINTED: 06/18/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION		E SURVEY PLETED
		245210	B. WING				
	PROVIDER OR SUPPLIER	245210	D. WING		EET ADDRESS, CITY, STATE, ZIP CODE	06/	12/2014
	NNETONKA SHORES	3		4527	SHORELINE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	inhalers belonged t the inhalers come i labels on, however, been thrown away. date on one of the was opened," howe handwritten date or was opened. During an interview coordinator (CC)-B ensured R115's inh medications should label and should be A review of the faci policy, undated, ins pharmacy permane outside of prescript with a label inserted	b identify which resident the o. TMA-A stated the boxes n from the pharmacy have the , R115's boxes must have TMA-A stated the handwritten inhalers was "probably when it ever, the other inhaler had no r label to determine when it on 6/12/14, at 3:35 p.m., care stated staff should have alers were labeled and verified a laways have a pharmacy e dated when opened. lity's Medication Labeling structed, "The dispensing ently affixes labels to the ion containers. Medications d into the vial or secured only or with worn or illegible labels	F	131			
EOBM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: ZR8211		Facility	ID: 00271 If continu	ation she	et Page 7 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	F5:	110022	FORM	: 06/18/2014 APPROVED . 0938-0391
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Z		CONSTRUCTION - MAIN BUILDING 01		E SURVEY IPLETED
		245210	B. WING	_	100	06/	10/2014
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 7 SHORELINE DRIVE		
	INNETONKA SHORES				RING PARK, MN 55384		
(X4) JD PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLET:ON DATE
K 000	INITIAL COMMENT	ſS	KO	000			÷
	FIRE SAFETY				Dec M		
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			POCOK PS 6-27 14		
Ze:	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE IS BEEN ATTAINED IN TH YOUR VERIFICATION.					
41-21-9	Minnesota Departm time of this survey, Building 1, was four compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	id at 42 CFR, Subpart id at 42 CFR, Subpart ity from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			DECENT		
7.	PLEASE RETURN CORRECTION FOI DEFICIENCIES ( K	R THE FIRE SAFETY			JUN 2 7 201		
EN	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Sulte 145			MN DEPT. OF PUBLIC S STATE FIRE MARSHAL D	AFETY	
	By email to:						
11	Nia CI B	ER/SUPPLIER REPRESENTATIVE'S SIGI		Ac	Ministrator	(0/	(X6) DATE
other salegua	ards provide sufficient pro date of survey whether or g the date these documer	tection to the patients. (See instruction not a plan of correction is provided. F	or nursing	t for nu home	may be excused from correcting providing ursing homes, the findings stated above an s, the above findings and plans of correction cited, an approved plan of correction is re	e disclosa on are disc	closable 14

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

PRINTED: 06/18/2014 FORM APPROVED

	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPL	E CONSTRUCTION	0	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILD	NING	01 - MAIN BUILDING 0	И	COM	PLETED
		245210	B. WING	_			06/1	0/2014
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, 527 SHORELINE DRIV			
	NNETONKA SHORES	3		s	PRING PARK, MN	55384		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION DTIVE ACTION SHOULD ICED TO THE APPROPH EFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to to correct the defici 2. The actual, or pr 3. The name and/o responsible for com prevent a reoccurre This 3-story buildin Type I (332) constr 1966 with additions partial basement and facility has a fire all detection in corrido corridor that is mor department notification in June of 2011, a constructed and de construction. It corr to the existing nurs from an attached a construction has a detection in the cor corridors, is fully fin monitored for autor	tate.mn.us RRECTION FOR EACH iT INCLUDE ALL OF THE DRMATION: what has been, or will be, done lency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. g was determined to be of uction. Original construction in in 1974 & 1982. It has a hd is fully fire sprinklered. The arm system with smoke rs and spaces open to the hitored for automatic fire	K	000				
	kitchen, community				see o	Hachmer	+	
FORM CMS-28	67(02-99) Previous Versione	Obsolete Event ID: ZR822		Fai	llity ID: 00271	If continu	ation shee	t Page 2 of 3

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

2

PRINTED: 06/18/2014 FORM APPROVED

CENTER	<b>RS FOR MEDICARE</b>	& MEDICAID SERVICES				OMB NO	D. 0938-039	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245210	B. WING			06		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP	CODE		
LAKE MI	NNETONKA SHORES	<b>j</b>			27 SHORELINE DRIVE RING PARK, MN 55384		-0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X6) COMPLETIO DATE	
K 000	Continued From pa	ge 2	KO	00				
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is need by:		1				
K 072 SS <del>≞</del> F	NFPA 101 LIFE SA	FETY CODE STANDARD	KO	72				
00±r	of all obstructions o use in the case of fi furnishings, decorat	e continuously maintalned free r impediments to full instant re or other emergency. No tions, or other objects obstruct ress from, or visibility of exits.						
	Based on observat has egress corridor LSC 7.1.10. These	s not met as evidenced by: ion and interview, the facility obstructions which violates obstructions could interfere and effective removal of gency situation.						
1	Findings Include:			5				
	on 06/10/2014, obs wheeled storage in	reen 9:45 AM and 11:30 AM ervation revealed that there is the corridors throughout the loes not have a categorical						
	This deficient practl Maintenance Manag inspection.	ce was verified by the ger at the time of the						
				-	see attachn Next Page	nent	1-31-1	
PM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:ZR6221		Facili	ly ID: 00271	If continuation st	leet Page 3 of	

Project Number F5210022	Provider Name: Lake Minnetonka Shores		Survey Date 6/10/2013	
dministrator: Lydia Buetow		Phone Number:	952 471 3907	
LBuetov	v@preshomes.org			

(X4) ID	<b>Provider's Plan of Correction</b>	Completion
PREFIX TAG	(Each corrective action must be cross-referenced to the appropriate deficiency.)	Date
K72 S/S=F	The facility will develop policies and practices which will allow it to utilize the categorical waiver issued by CMS regarding wheeled equipment storage in corridors as described in S&C: 13-58-LSC. The facility Director of Engineering, Director of Nursing, and Nursing Home Administrator, in conjunction with the regional engineering dept. will develop these written policies and practices as well as written documentation that the facility has elected to use the waiver and certify the facility meets the conditions outlined in LSC 101 (12) 19.2.3.4 (4) The facility staff will present that documentation to the LSC survey team at the entrance conference. The NHA, Director of Engineering, and DON will conduct periodic audits of staff training to ensure the policies and practices are adhered to. These policies, training schedules, and audits will be developed and put into practice by July 31 <sup>st</sup> , 2014	

D PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E		E CONSTRUCTION ( 02 - BLDG TWO	COM	E SURVEY PLETED	
245210			B. WING			06/	06/10/2014	
	PROVIDER OR SUPPLIER	•		4	TREET ADDRESS, CITY, STATE, ZIP CODE 527 SHORELINE DRIVE PRING PARK, MN 55384			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
K 000	INITIAL COMMENT	ſS	к	000				
	FIRE SAFETY				22.14			
	Minnesota Departm time of this survey, Building 2, was four with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National F	Survey was conducted by the tent of Public Safety. At the Lake Minnetonka Shores, and in substantial compliance its for participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association D1, Life Safety Code (LSC), ealth Care.			P8 6-27-14			
	constructed and de construction. It con to the existing nursi from an attached as construction has a to detection in the corri corridors, is fully fire monitored for autom	s 1-story building was termined to be of Type II (222) tains a basement, is attached ng home and is fire separated ssisted living facility. The new 'ire alarm system with smoke ridors and spaces open to the e sprinkler protected and is natic fire department w construction contains the room and chapel.			a d			
	census of 134 beds	apacity of 145 beds and had a at the time of the survey.						
	MET.	42 CFR, Subpart 483.70(a) is						
		1						
-11	dia SIIS	ER/SUPPLIER REPRESENTATIVE'S SIGN		A	dMin 1Strictw on may be excused from correcting providing it	Ć	(X6) DATE 2/27/	

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