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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZR82

Facility ID: 00271

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245210

2. STATE VENDOR OR MEDICAID NO. (L2) 172043100

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

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

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

6. DATE OF SURVEY 07/28/2014 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) 09/30

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

12. Total Facility Beds 145 (L18)

13. Total Certified Beds 145 (L17)

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

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

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

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date: Holly Kranz, HFE NE II 08/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kate JohnsTon, EnforcementSpecialist 09/22//2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00320 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kate Johnston

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kate Johnston

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245210	A. Building B. Wing	7/28/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	**06/27/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**07/11/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	08/21/2014	33561	07/28/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/12/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245210	A. Building B. Wing 01 - MAIN BUILDING 01	8/4/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 07/31/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	08/21/2014	28120	08/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/10/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZR82

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245210**

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

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

6. DATE OF SURVEY **06/12/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Christine Bodick-Nord, HFE NE II 07/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 08/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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:

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;

- 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 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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING _____ B. WING _____	C 06/12/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation had also been completed at the time of the standard survey. An investigation of complaint H5210044 had not been substantiated during this survey.	F 000	**F000** **This plan and response to these survey findings is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement nor an agreement with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations.**	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent federal survey results were posted in a	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/27/14

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.

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LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 55384

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F 167	Continued From page 1 place which was visible and readily accessible for all residents to review. This had the potential to effect all 134 residents residing in the facility, family, and visitors. Findings include: During the initial tour of the facility on 6/9/14, at 1:15 p.m., the federal survey results, nor a sign indicating where to find the survey results, were able to be located. During observation on 6/9/14, at 3:10 p.m. a plastic bin was located across from the medication room and labeled "quality concern forms" on the third floor. Behind the quality concern forms was a sheet of paper inside a protective sheath that noted "The Survey results are available outside TCU (transitional care unit) dining room." During observation on 6/9/14, at 3:20 p.m. an unlabeled plastic bin was located across from the elevator on the second floor. Quality concern forms were inside of the bin and there was no label indicating what the bin contained. Behind the quality concern forms, which was in the unlabeled protective sheath, was a sheet of paper that noted "The Survey results are available outside TCU dining room." During observation on 6/9/14, at 3:30 p.m. there was an unlabeled plastic bin located outside the TCU dining room on the first floor, however, the bin was empty. During observation on 6/10/14, at 9:07 a.m., a binder was located in the top drawer outside the conference room on first floor, directly across	F 167	**F 176 Corrective Action:** 1. Corrective Action: The Survey 2013 was moved to the plastic bin outside of the TCU Dining Room. Posters were placed in a singe flat mounted hard plastic sleeve on all floors indicating where to find the Survey Results 3 Ring Binder. 2. Corrective Action as It Applies to other residents: At the next scheduled Resident Council/Family Council the survey results and location from 2014 will be discussed with resident and family. This will be documented in the notes from the meeting. Posters are displayed on all floors as to where to find the Survey Results. The Survey Book is displayed outside of the TCU Dining Room where many residents travel by and activities are held. 3. Date of Completion: 6/27 /2014	6/27/14

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LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 55384

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F 167	Continued From page 2 from the elevators. The outside of the binder was labeled 2013 survey results. The drawer was closed, and there was no sign indicating the survey results were located in the drawer. During interview on 6/9/14, at 6:41 p.m. family member (F)-B stated she was not aware of the location of the survey results. During interview on 6/10/14, at 9:40 a.m. F-A stated she was not aware of the location of the survey results. During tour on 6/10/14, at 11:23 a.m., the administrator stated the survey results should have been posted outside the TCU dining room but were not. The administrator verified it was difficult to find the survey results, and the signs which were in the plastic bins did not direct residents or family to where the current survey results were posted. During interview on 6/11/14, at 10:03 a.m., R104, (who was the secretary for the third floor resident council), stated the last resident council meeting was held on March 6th, 2014. R104 was unaware of where the facility survey results were posted, does not recall that being gone over in the meeting, and thought she would have to view them on a staff members computer if she wished to see them. During interview on 6/11/14, at 10:33 a.m., R32 stated she attended resident council meetings and could not recall the facility survey results being discussed at the meetings but was "interested to know that [where to locate the results for review]" so she could review them.	F 167	4. Reoccurrence will be prevented by: Audits will be done 1x weekly by the assigned Household Coordinator on Each Floor to check for the poster alerting residents/family where the Survey Results are located. The Household Coordinator for TCU will audit 1x weekly for proper placement of the results outside the TCU Dining Room. Household Coordinators will interview 3 family or residents weekly to make sure they are aware of the location of the Survey Results. The 3 Ring Binder will be updated to Survey results including any extended Surveys, follow up visit reports, and along with state approved plans of correction of noted deficiencies by the Administrator or designee. 5. The Correction will be monitored by: a. The audits will be given to the Administrator for review. b. Administrator will report audits to the QA Team. QA will determine	

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F 167	Continued From page 3 On 6/11/14, at 10:46 a.m., the facility resident council meeting minutes were reviewed for the previous 11 months and there was no evidence the survey results and the resident's right to have access to them was reviewed with the resident's. The Facility policy titled Examination of Survey Results created 11/2003, noted a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisit reports, etc., along with the state-approved plans of correction of noted deficiencies, is maintained in a 3 ring binder or folder located in an area frequented by most residents, such as the main lobby or activity area.	F 167	frequency of audits c. The Administrator will be responsible for compliance.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	**F431** 1. Corrective Action: The opened or expired meds were immediately removed from the med room and the inhaler from the med cart. 2. Correction Action as it applies to others: An immediate review was completed of all med carts/med rooms to ensure no other like meds were available to residents. An in-service will be scheduled for the week 7/7/2014 for Nurse/TMA regarding proper storage medication including labeling and open dates. In-service will include which medication are in need of destruction related to dates opened. 3. Date of Completion: 7/11/2014	7/11/14

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LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 55384

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F 431	Continued From page 4 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to establish a system to ensure stock supply of expired medications were removed to prevent further resident use and failed to ensure medications which had been opened were dated to ensure they were not used after expiration, for 1 of 3 medication storage rooms, where expired medications remained available for use and contained opened and unlabeled medication. This had the potential to affect all 29 residents that currently resided on the Transitional Care Unit. In addition, the facility failed to ensure proper labeling of inhalers for 1 of 1 residents, (R115) who used an inhaler which was not labeled. Findings include: During an observation on 6/12/14, at 2:17 p.m., the medication storage room refrigerator on the 1st floor Transition Care Unit (TCU), contained a box of Biscolax 10 mg suppositories (rectal medication used to stimulate bowels) which	F 431	4. Reoccurrence will be prevented by: The Clinical Coordinator or designee will audit medication storage areas weekly for compliance by visually inspecting medication storage areas reviewing outdated meds and opened meds in need of destruction. The staff will have an in-service regarding proper storage/labeling of medication for resident use. Merwin Pharmacy will be involved with quarterly review of med pass and storage. 5. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator for review. b. The Clinical Administrator will present to QA Team to review. QA will determine frequency of audits. c. The Clinical Administrator will be responsible for compliance.	

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F 431	Continued From page 5 expired on 4/14. Clinical coordinator (CC)-A was present at the time of observation and verified the product was expired, 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 09/2008, 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 Dulcolax 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 assistant (TMA)-A was present during the observation and verified the inhalers did not have	F 431		

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F 431	Continued From page 6 a pharmacy label to identify which resident the inhalers belonged to. TMA-A stated the boxes the inhalers come in from the pharmacy have the labels on, however, R115's boxes must have been thrown away. TMA-A stated the handwritten date on one of the inhalers was "probably when it was opened," however, the other inhaler had no handwritten date or label to determine when it was opened. During an interview on 6/12/14, at 3:35 p.m., care coordinator (CC)-B stated staff should have ensured R115's inhalers were labeled and verified medications should always have a pharmacy label and should be dated when opened. A review of the facility's Medication Labeling policy, undated, instructed, "The dispensing pharmacy permanently affixes labels to the outside of prescription containers. Medications with a label inserted into the vial or secured only by a rubber band, or with worn or illegible labels will not be accepted."	F 431		

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

F5210022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/10/2014

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Shores, Building 1, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok JB 6-27-14 RECEIVED JUN 27 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

POC
EXIT: 6-12-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julia A Bluttau | TITLE: Administrator | (X6) DATE: 6/27/14

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.

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	245210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/10/2014

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K 000	Continued From page 1 Marlan.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type I (332) construction. Original construction in 1966 with additions in 1974 & 1982. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. In June of 2011, a 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement, is attached to the existing nursing home and is fire separated from an attached assisted living facility. The new construction has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, is fully fire sprinkler protected and is monitored for automatic fire department notification. The new construction contains the kitchen, community room and chapel. The facility has a capacity of 145 beds and had a census of 133 beds at the time of the survey.	K 000	see attachment	

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	245210	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2014**

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

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 9:45 AM and 11:30 AM on 06/10/2014, observation revealed that there is wheeled storage in the corridors throughout the facility. The facility does not have a categorical waiver. This deficient practice was verified by the Maintenance Manager at the time of the inspection.	K 072	See attachment next page	7-31-14

Project Number F5210022	Provider Name: Lake Minnetonka Shores	Survey Date 6/10/2013
Administrator: Lydia Buetow LBuetow@preshomes.org		**Phone Number:** 952 471 3907
State Fire Inspector: Bob Rexeisen 612 386 4657		

(X4) ID PREFIX TAG	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion 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 31st, 2014	***07/31/2014***

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

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	245210	A. BUILDING **02 - BLDG TWO** B. WING _____	**06/10/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Shores, Building 2, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18, New Health Care. In June of 2011, this 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement, is attached to the existing nursing home and is fire separated from an attached assisted living facility. The new construction has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, is fully fire sprinkler protected and is monitored for automatic fire department notification. The new construction contains the kitchen, community room and chapel. The facility has a capacity of 145 beds and had a census of 134 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	FR 6-27-14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lydia J Bueltan — TITLE: Administrator — (X6) DATE: 6/27/14

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