Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 19, 2022

Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

RE: CCN: 245210
Cycle Start Date: August 16, 2022

Dear Administrator:

On August 26, 2022, we notified you a remedy was imposed. On September 12, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 8, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 10, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 26, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 10, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 8, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 19, 2022

Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Re: Reinspection Results
Event ID: SYJ912

Dear Administrator:

On September 12, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 12, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2022

Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

RE: CCN: 245210
Cycle Start Date: August 16, 2022

Dear Administrator:

On August 16, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 10, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 10, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 10, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 10, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lake Minnetonka Shores will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 10, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 16, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161   Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 08/16/2022

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	F 000		

On 8/15/22, through 8/16/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaint were found to be SUBSTANTIATED:
H52103948C (MN85893), with a deficiency cited at F689 & F697.

In addition, as a result of the investigation a related deficiency was cited F625.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		9/8/22

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/02/2022

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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F 625 Continued From page 1

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the resident or their representative, a bed hold notice for 1 of 1 residents (R1) reviewed for hospitalizations.

Findings include:

R1's diagnoses included rheumatoid arthritis (RA), other chronic pain, contractures of the right and left knees, and Arthritis obtained from the annual Minimum Data Set (MDS) dated 5/3/22. In addition, the MDS identified R1 had intact cognition.

During review of the medical record, it was revealed R1 on 8/7/22, was transferred to an acute hospital however, the interdisciplinary notes

F 625

"This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board."

F625 SS=D Bed Hold Policy

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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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F 625	Continued From page 2 lacked documentation of a bed hold notice being provided to R1 or their representative. During review of a general late entry note dated 8/7/22, at 8:15 p.m. it was revealed the writer at 9:40 p.m. had spoken with family member (FM)-A to give an update however, there was no evidence FM-A was informed of the bed hold. The note further indicated at 10:22 p.m. left the facility with emergency medical services however, R1 was not provided the bed hold notice. During interview on 8/16/22, at 9:04 a.m. the director of nursing (DON) stated the social worker was responsible for letting residents and the responsible parties about the bed hold and this was supposed to be documented in the medical record. During interview with the clinical administrator (CA), on 8/16/22, at 9:04 a.m. the CA stated the social worker was responsible for providing bed holds and the social worker was supposed to document in the medical record. During interview on 8/16/22, at 11:14 a.m. the facility administrator acknowledged R1's medical record lacked documentation of a bed hold notice being provided. The administrator acknowledged all resident's regardless of their payment source. The facility Bed Hold policy modified April 2018, directed "Before a resident leaves for hospitalization or therapeutic leave, the facility will attempt give the resident a copy of the bed hold policy. The Resident Services staff or designee will contact the resident/responsible party to inquire about bed hold. Discussion regarding bed hold will be documented in the progress notes..."	F 625	Date of Compliance: 9/8/22 Corrective Action: R1 remains in the hospital. R1s emergency contact was notified of the bed being held. The Bed hold Policy was reviewed and remains current. Education on the Bed Hold policy will be completed for all Licensed staff and Household Coordinators by 9/8/22. Corrective Action as it Applies to Other Residents: An audit of all current residents that are in the hospital and or on an LOA will be completed to ensure written information of the bed hold policy is given to the resident and/or family member/legal representative per policy. Reoccurrence will be Prevented By: An audit will be completed for each unplanned transfer or LOA. The Administrator or designee will audit each unplanned transfer or LOA during the IDT process for compliance for 12 weeks. The Administrator or designee will be responsible for compliance. Audits will be reported to the QAPI team to determine ongoing need for audits.	

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess resident equipment to ensure appropriateness and safety when using a shower chair for 1 of 1 resident (R1) who had a fall while receiving a shower. This resulted in actual harm for R1 who was hospitalized, and was diagnosed with compression fractures of L4-L5 and impacted transverse fracture of the proximal tibial shaft extending into the tibial plateaus reviewed for accidents. Findings include: R1's diagnoses included rheumatoid arthritis (RA), other chronic pain, contractures of the right and left knees, and arthritis obtained from the annual Minimum Data Set (MDS) dated 5/3/22. In addition, the MDS identified R1 had intact cognition. R1's activities of daily living (ADL) care plan identified R1 had a self-care performance deficit related to limited range of motion (ROM), contractures, activity intolerance, RA and chronic pain. The care plan directed staff for bathing "I require assist of two using the full lift for transfers	F 689	F689 SS=G Free of Accident Hazards/Supervision/Devices Date of Compliance: 9/8/22 Corrective Action: An order for R1 was received on 7/29/22 for OT to evaluate resident for positioning in shower chair. Resident declined this at that time. R1 remains in the hospital and upon return will be comprehensively assessed, including being assessed for proper positioning devices needed in wheelchair and shower as indicate Education will be completed with all nursing staff on the Change of Condition, Physician Notification and Occurrence Reporting policies by 8/31/22. Corrective Action as it Applies to Other Residents: A facility audit of all residents was completed to ensure that they are positioned correctly in their shower chairs to ensure safety during showers. Any positioning concerns will be referred to therapy for evaluation.	9/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689

Continued From page 4
and one assist staff participation with bathing."

On 8/15/22, the shower chair which R1 was using at the time of the fall was observed stored in the Spa room. The rolling wheeled shower chair was constructed out of Polyvinyl chloride with a straight mesh covered backing and had a blue open front soft vinyl cushion seat with a donut cut out bottom. No safety belts were observed on the chair. The chair could also be used as a commode.

Incident Occurrence Report dated 7/28/22, at 10:30 a.m. revealed while in the shower after having the shampoo rinsed out of her hair and was having conditioner put in her hair R1 slipped off the shower chair and fell to the floor. At the time of the fall R1 was being assisted by nursing assistant (NA)-A who witnessed the fall. The staff indicated "Analysis as the cause of occurrence: Poor posture related to [R/T] co-morbidities. Action to Minimize Reoccurrence: Occupational [OT] to evaluate shower chair positioning."

During review of the interdisciplinary notes the following was revealed:
-Fall description note dated 7/28/22, at 11:38 indicated at 10:30 a.m. while in the shower after having the shampoo rinsed out of her hair and having conditioner put in R1's hair R1 slipped off the shower chair. R1 was being assisted, and the fall was witnessed and due to R1's size and body alignment, staff was unable to intervene as R1 slipped off the shower chair onto the right side. The note then indicated after the fall R1 rested on the shower room floor on the right side, both knees bent resting on the right shoulder with arm underneath R1. The note also indicated the witness believed R1 did not hit her head but was

F 689

Reoccurrence will be Prevented by: The Occurrence Reporting Policy and Change of Condition Physician Notification policy were reviewed and remain current. All nursing staff will be re-educated on the Change in Condition Physician Notification policy and Occurrence Reporting policy. The Clinical Administrator and/or designee will conduct bathing audits to ensure proper positioning and safety on 10% of residents weekly for 12 weeks. In addition to bathing audits, weekly Quality assurance meetings will be conducted with the floor staff, Clinical coordinators, Household coordinators and the Clinical administrator and/or Administrator, to identify and ensure any changes in resident conditions are addressed in a timely manner.

The Clinical Administrator and/or designee is responsible for ongoing compliance. Audit results will be reported to QAPI team to determine ongoing need for audits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 5	F 689		

unable to say for sure. The note then indicated R1's pain was reported as unchanged from prior to the shower. R1 was examined for injury, none noted and then was assisted with four staff and a full body lift into the manual wheelchair, was assisted to her room and into the bed. R1 complained of the right lower extremity (RLE) hurting. The note further indicated the responsible parties, and the nurse practitioner (NP) were notified of the fall and an order was obtained for X-ray to be completed and R1 was noted to have bruising on both knees, left forearm and the left knee there was a 4.0 centimeter (cm) light bruise and skin was intact. The note did not indicate the level of pain R1 had prior to the fall.

-PN dated 7/29/22, at 8:54 a.m. indicated the NP was updated on R1's current status and staff had obtained an order for OT to evaluate and treat, assess cognitive changes as well as shower chair positioning.

-Interdisciplinary team (IDT) follow up analysis PN dated 7/29/22, at 12:34 p.m. indicated R1 had fallen on 7/28/22, at 10:30 a.m. in shower. The noted indicated R1's hair had been washed and rinsed but the body was soapy and was seated "on the shower chair she prefers when showering." The nurse wrote "WAS IT ASSESSED TO BE APPROPRIATE & DEEMED SAFE PRIOR TO FALL? She sat with "her usual abnormal body alignment, head down and leaning to the right at the shoulders. It may be possible she fell asleep while having her hair washed, leaned forward, and went to the floor. Staff had hands on assist and care plan was followed. She landed on her right side; knees bent. She offered complaints of pain that compared to same pain reported prior to assist with shower per chronic

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 08/16/2022

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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F 689	Continued From page 6 pain noted." The note further indicated R1 had complained of feet hurting. X-ray was ordered. X-ray results noted negative results for fractures on the left foot and ankle, and right foot and ankle. The note did not address and/or respond if the shower chair had been assessed to be appropriate and safe for R1 to use despite R1's "usual abnormal body alignment" and no seat belt. Progress notes from 7/28/22-8/7/22 revealed documentation of R1 reporting consistent pain, refusing activity and receiving more than average amounts of PRN medication. The hospital imaging report dated 8/7/22, revealed R1 was found to have the following fractures: -There are moderate compression fractures of indeterminate age involving the superior L4 and L5 vertebral bodies resulting in increased L3-4 and L4-5-disc height. - An impacted transverse fracture of the proximal tibial shaft, extending into the tibial plateaus, with mild varus angulation on the left knee. On 8/15/22, at 1:35 p.m. NA-A stated prior to assisting R1 with the shower on the day R1 fell out of the shower chair, she and another staff had completed the shower the previous week with her observing and doing hands on care (training observation). NA-A stated she and NA-C had transferred R1 into the shower chair and then took R1 into the Spa room where they weighed R1 and then NA-C left her to assist with the shower. NA-A stated after washing and rinsing R1's hair between the shampoo and conditioner she had looked away from R1 to grab the conditioner for R1's hair and in that split second	F 689		

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R1 fell out of the shower chair. NA-A stated the distance she had to travel in that split second was approximately a foot length. NA-A stated she was not sure what would have led to the fall to happen but thought it was a combination of R1's abnormal posture and the shower chair being slippery. NA-A stated following the fall she had not received any training but had been involved in discussions on using another shower chair for R1 and using two staff to assist with the bathing. NA-A further stated when R1 was seated on the regular wheelchair she felt R1 did not need help to stabilize, but when in the shower chair NA-A felt she had to hang on to R1 to provide to stabilize her because the chair had an upright back and was not fitted for her abnormal postured like her wheelchair.

During interview on 8/15/22, at 12:50 p.m. the NP stated following the fall her colleague had taken the call regarding R1's fall. NP stated she had then received a call 7/28/22, requesting for an order for OT to evaluate the use of the shower chair and then she returned the call on 7/29/22.

During interview on 8/15/22, at 11:20 a.m. the clinical administrator stated she had been notified about the fall. The CA then stated, "I wish you could see [R1] the big part of this is her posture and she may have shifted." The CA stated since the fall she had been out of the building, however, with briefly discussing about the fall after it happened, the staff thought she could have been slippery from the shower and the shower chair may not be agreeable with her posture as resident had an abnormal posture issue. When asked if the shower chair had been assessed to be appropriate and safe for R1 to use during shower related to the progression in her disease

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and posture, the CA stated she could not speak about the chair and knew ??felt??the right size of chair was being used at the time of the fall. The CA directed surveyor to the director of therapy to provide information on when therapy had evaluated R1.

During interview on 8/15/22, at 11:44 a.m. therapy director reviewed the therapy episodes R1 had attended since January 2021 and the medical record lacked documentation of the therapy department evaluating R1's shower chair appropriateness related to R1's postural abnormality. The director of therapy stated due to R1's abnormal posture they had evaluated R1's wheelchair to ensure it was working for R1. The therapy director stated there had not been an assessment done with OT as there was nothing that had been triggered to make them to look at it. The therapy director stated the "preferred shower chair" was something R1 liked and did not want to use the regular tub chair.

During interview on 8/15/22, at 12:19 p.m. the OT stated she had not officially evaluated R1 before the fall in the shower chair but had seen R1 being transported in it in and out of shower, however, nursing had never reported concerns of R1 having positioning problems prior to the fall. OT stated not all residents were evaluated for the shower chairs and nursing would have to make the decision and assess if they had any questions they would seek out to therapy, who would get a referral and order to look into it.

During interview on 8/15/22, at 12:33 p.m. the facility administrator stated following the incident the staff involved were given real time education, however, not sure if this was formal education.

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F 689	Continued From page 9 The administrator further stated no staff education had been implemented following the incident as they felt the staff was doing the correct thing and had followed the care plan. During a follow up interview with the clinical administrator, on 8/16/22, at 9:04 a.m. the CA stated for the shower chair if staff had brought the concern for positioning to management, it would have been assessed and addressed but this never happened and R1 never complained. The CA stated, "Our plan after the fall was for [R1] to be assessed by therapy for safety." The CA acknowledged no assessment had been completed on R1 using the shower chair despite R1's posture changes over time which required other devices to be evaluated by therapy for safety and appropriateness. The CA stated staff education was needed, and she acknowledged R1 had changed, and the appropriateness of the shower chair should have been assessed as R1 was not even the same now in comparison to four months ago. The CA acknowledged R1's posture had changed over time however the shower chair had not been assessed to determine if the shower chair needed a safety belt to provide and secure R1 from falling during showers or to determine if a different shower chair would be appropriate.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		9/8/22

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F 697	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure complaints of worsening acute generalized pain were comprehensively assessed and treated in a timely manner to provide comfort and reduce risk of complications for 1 of 1 residents (R1) who voiced concerns about pain following a fall. This resulted in actual harm when after a fall R1 experienced increasing, ongoing pain with decreased mobility and was subsequently hosptialized for fractures. Findings include: R1's diagnoses included rheumatoid arthritis (RA), other chronic pain, contractures of the right and left knees, and Arthritis obtained from the annual Minimum Data Set (MDS) dated 5/3/22. The MDS identified R1 had intact cognition, was on scheduled and as needed pain medication and R1 reported frequent pain, however did not limit her from day to day activities and sleep at night. The facility did not provide evidence of pain assessment completed for R1 prior to or after the fall. R1's pain care plan dated 2/2/22, identified R1 had chronic managed pain related to rheumatoid arthritis, peripheral vascular disease, decreased mobility, contractures, and history of left tibia fracture. The care plan directed staff nurses to monitor the effectiveness of pain interventions, notify the physician if interventions are unsuccessful or if current complaint was a significant change from R1's past experience of pain and nurses were to identify, record and treat R1's existing conditions which may increase pain	F 697	F697 SS=G Pain Management Date of Compliance: 9/8/22 Corrective Action: R1 was sent to the hospital for evaluation and treatment. The Pain Assessment and Management Policy was reviewed and remains current. Education with all nursing staff will be completed with the facility Medical Director on the Change of Condition Physician Notification Policy. The Clinical administrator educated the clinical coordinators on daily PRN medication audit reviews and IDT expectations on 9/1/2022. Education regarding the Pain Assessment and Management Policy will be completed by 9/8/22. Corrective Action as it Applies to Other Residents: A facility audit of all current residents was completed to identify any new onset of pain, increase of pain or significant change of condition. If any concerns were identified, a pain assessment was completed. Reoccurrence will be Prevented by: Clinical Administrator/or designee will review the PRN medication audit report daily x 2 weeks and weekly for 10 weeks for trends of increased PRN pain medication use. Clinical coordinators will report any new or worsening pain per IDT review. The audits will be reviewed by clinical administrator and/or care center administrator. Weekly Quality assurance	

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F 697	Continued From page 11 and or discomfort. Incident Occurrence Report dated 7/28/22, at 10:30 a.m. revealed R1 while in the shower after having the shampoo rinsed out of her hair and was having conditioner put in her hair when R1 slipped off the shower chair and fell to the floor. During review of the Falls Huddle Review Form dated 7/28/22, revealed R1 had indicated "I hurt allover" however, staff wrote to the side "commented prior to shower as well." During review of the interdisciplinary notes the following was revealed: -Fall description note dated 7/28/22, at 11:38 indicated at 10:30 a.m. while in the shower after having the shampoo rinsed out of her hair and having conditioner put in R1's hair R1 slipped off the shower chair. The note then indicated R1's pain was reported as unchanged from prior to the shower. R1 was examined for injury, none noted and then was assisted with four staff and with a full body lift into the manual wheelchair, was assisted to her room and into the bed. R1 complained of the right lower extremity (RLE) hurting. The note further indicated the nurse practitioner (NP) was notified of the fall and an order for an X-ray was obtained. The note did not indicate the level of pain R1 had prior to the fall. X-ray results noted negative results for fractures on the left foot and ankle, and right foot and ankle. -Fall follow up PN dated 7/28/22, at 8:55 p.m. indicated R1's range of motion (ROM) was limited at baseline, R1 complained of "general pain with movement" and both as needed (PRN) and scheduled pain medications were administered.	F 697	meetings will be conducted with the floor staff, Clinical coordinators, Household coordinators and the Clinical administrator and/or Administrator, to ensure changes in resident□s pain control are identified timely. The Clinical Administrator and/or designee is responsible for ongoing compliance. Audit results will be reported to QAPI team to determine ongoing need for audits.	

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F 697	Continued From page 12 The note did not indicate the level of pain assessed. -Fall follow up PN dated 7/29/22, at 12:52 a.m. indicated "ROM limitation as her baseline related to contractures. Writer assessed resident's pain as follow up from evening report with oxycodone administration at 9:53 p.m., resident stated "a little bit on my whole body" when asked to rate current pain on a scale of 0-10, resident complained "1-2" pain med was effective." -Fall follow up PN dated 7/29/22, at 1:44 p.m. R1 complained of pain all over about 9:26 a.m. was given PRN oxycodone 10 mg. R1 stated she will get up at 10:30 a.m. and when staff went to get her up, she requested to get up at 12:00 p.m. then at 1:00 p.m. R1 requested 10 more minutes. Staff then assisted to get R1 up about 1:30 p.m. at which R1 had pain with movement and repositioning and the pain was general pain. -Fall follow up PN dated 7/30/22, at 5:10 a.m. nurse had administered PRN oxycodone per R1's request for pain rated 8 out of 10 with pending effect. -Fall follow up PN dated 7/30/22, at 11:49 a.m. indicated R1 did complain of nausea again, but no vomiting. Resident stated, "My legs are killing me." Oxycodone 10 mg given with relief and R1 noted to have dark purple bruises on both knees, right thigh had a larger bruise that was turning purple and deep purple bruise remained to left wrist. The noted did not indicated the physician/provider or on-call had been called for R1's expression of her legs killing her. -PN dated 7/31/22, at 4:30 a.m. indicated due to	F 697		

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F 697	Continued From page 13 too much general body pain, PRN oxycodone was administered per resident request for pain rated 8 out of 10 after non-pharmacological intervention was ineffective. -Fall follow up PN dated 7/31/22, at 10:06 indicated R1 requested oxycodone for leg pain. "My legs are killing me." Bruising on left leg was extending down to upper calf. R1 refused Ace wraps due to the pain, but it was not unusual for R1 to refuse ace wraps. R1 also would not allow the writer to elevate the head of bed (HOB) due to pain it caused. R1 continued to complain of pain to her legs from the fall. The note lacked documentation of the physician being notified for the resident expression of pain and continued complaints of pain including refusing the HOB to be elevated. -PN dated 8/1/22, at 1:49 p.m. R1 at 1:15 p.m. had requested to be assisted out of bed and prior to touching the covers on her bed R1 began to say, "Ouch Ouch Ouch." The writer then asked R1 where she hurts and R1 responded "all over." The writer then asked where exactly she was hurting, but R1 would not give details. The note indicated after the cares R1 transferred out of bed using a full body lift and R1 complained of pain during transfer but refused to offer specific details. The nurse indicated R1 did not have subjective signs of discomfort noted other than the verbal reports and she had called the NP and left message related to complaint of pain. -PN dated 8/5/22, at 10:01 a.m. indicated R1 had complained of pain during transfer in/out of bed to wheelchair and when the nurse offered pain medication R1 refused to take before she left for an appointment.	F 697		

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-Late entry PN dated 8/7/22, at 7:00 p.m. indicated R1 had complained of generalized pain at approximately 5:30 p.m. R1 had rated the pain 5 out of 10 and did not identify specific origin of pain stating, "I hurt everywhere." R1 and oxycodone 5 mg was given at 5:49 p.m.

-Late entry PN dated 8/7/22, at 8:15 p.m. indicated the writer received notification from the trained medication aide (TMA) that R1's family requested a transfer to hospital at approximately 8:17 p.m. via phone call. Writer approached R1 who reported FM-A wanted her to go in. R1 further complained of having all over generalized pain rating it 12 out of 10. When questioned further on pain origin R1 indicated she was experiencing the pain in her legs. During assessment R1 was grunting.

Records indicated R1 was transferred to the hospital at 10:22 p.m. per FM-A request.

The hospital imaging report dated 8/7/22, revealed R1 was found to have the following fractures:
-There are moderate compression fractures of indeterminate age involving the superior L4 and L5 vertebral bodies resulting in increased L3-4 and L4-5-disc height.
- An impacted transverse fracture of the proximal tibial shaft, extending into the tibial plateaus, with mild varus angulation on the left knee.

During review of the Medication Administration Record (MAR) for July and August 2022 the following was revealed:
-7/1/22 through 7/27/22, prior to the fall R1 had requested the PRN oxycodone 10 mg 15 times in

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27 days

-7/28/22 through 8/7/22, after the fall R1 had received PRN oxycodone 10 mg 25 times in 9 days of which resident rated her pain 7 to 10

Although staff nurses had contacted the NP on 7/29/22, and 8/1/22, the notes did not indicate specifics of what the NP had been updated on and the recommendation from the provider. In addition, the medical record lacked documentation of the nurses doing follow up with the NP and/or provider on-call about the complaints of pain and the increase in PRN pain medication.

During interview on 8/15/22, at 4:34 p.m. FM-A stated after the fall, they had reached out to the facility and had been told R1 had been x-rayed and there were no results. FM-A stated they had received multiple messages from R1 indicating how she had pain and at some point when FM-A had spoken with R1 they had noticed R1 was experiencing a "little delirium" and thought it may have been from all the pain medication R1 had been receiving following the fall. FM-A stated after 11 days of R1 being at the facility and feeling nothing was being done, they had requested to have R1 be evaluated at the hospital where she was found to have fractures as the hospital x-rays for the whole body were completed to rule out and identify the cause of the pain R1 was experiencing.

During interview on 8/15/22, at 9:32 a.m. nursing assistant (NA)-A stated although R1 had chronic pain, after the fall she had noticed the pain had increased and R1 would tell them she was hurting all over and even before you touch her, she would

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complain of pain. NA-A stated, "When she had the pain, we would let the nurses know and I think they were giving her Tylenol or something not sure what."

During interview on 8/15/22, at 9:43 a.m. registered nurse (RN)-A stated the policy was when a resident had a change of condition and a new acute onset of pain she would administer the PRN pain medication, follow up with the provider, follow up with the resident if the medication was effective and then would follow up with the provider if she did not hear from them to make sure the issue was addressed.

During interview on 8/15/22, at 12:50 p.m. the NP stated following the fall her colleague had taken the call regarding R1's fall. NP stated she had then received a call 7/28/22, requesting an order for OT to evaluate the use of the shower chair and she had returned the call on 7/29/22. NP then stated she had subsequently received a call on 8/1/22, and was informed about the pain and that the pain medication oxycodone had been administered. NP also stated she was off from work on 8/2/22, through 8/7/22, however, during her absence she had her colleagues cover for her. The NP stated she had reviewed the calls which had been made to the colleagues and there was no documentation of staff nurses calling regarding the increased acute pain R1 was experiencing following the fall, the verbalization of pain and the increased use and need for PRN narcotics. The NP stated, "It's hard to say if they should have called me because of her long history of chronic pain but I would have wanted them to call if she was using the PRN's more as there was someone covering for me while I was away. They should have called

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because she had increased PRN use, crying, moaning and at times not wanting to get out of bed." The NP further stated she had reviewed the notes from her colleagues and there had not been any calls until 8/7/22, night when she gave the order to send R1 to the hospital.

During interview on 8/15/22, at 11:20 a.m. the clinical administrator (CA) reviewed the interdisciplinary and nursing notes and stated there was notes of the staff nurses updating the NP on 7/28/22, 7/29/22 and 8/1/22, about the pain. The CA stated the expectation was the nurses were to notify the provider if R1 had increased pain after being assessed and the nurses should have done a follow up with the provider when the pain continued, and they had not heard from the provider.

During a follow up interview on 8/16/22, at 9:04 a.m. the CA stated the nurse should have called back the provider to notify the provider R1 was still experiencing the pain and was taking that many narcotics.

The facility Pain Assessment and Management Policy Modified: November 2016, directed staff the following:
"3. Notify MD of pain assessment findings if pain is indicated to start or change pain management program as necessary with on going evaluation of effectiveness of medications prescribed.
4. Follow prescribed orders for pain management-documenting results in the eMAR for PRN
medications using provided pain scale of 0-10. For residents on scheduled pain medications, document effectiveness routinely and notify MD or Nurse Practitioner if/when change in

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F 697	Continued From page 18 medication regimen is needed..."	F 697		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 26, 2022

Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Re: State Nursing Home Licensing Orders
Event ID: SYJ911

Dear Administrator:

The above facility was surveyed on August 15, 2022 through August 16, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00271	A. BUILDING: ______ B. WING ______	08/16/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/15/22, through 8/16/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52103948C (MN85893) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 830	Continued From page 2	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess resident equipment to ensure appropriateness and safety when using a shower chair for 1 of 1 resident (R1) who had a fall while receiving a shower. This resulted in actual harm for R1 who was hospitalized, and was diagnosed with compression fractures of L4-L5 and impacted transverse fracture of the proximal tibial shaft extending into the tibial plateaus reviewed for accidents. Findings include: R1's diagnoses included rheumatoid arthritis (RA), other chronic pain, contractures of the right and left knees, and arthritis obtained from the annual Minimum Data Set (MDS) dated 5/3/22. In addition, the MDS identified R1 had intact	2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General (State Nursing Home Licensure) Date of Compliance: 9/8/22 Corrective Action: An order for R1 was received on 7/29/22 for OT to evaluate resident for positioning in shower chair. Resident declined this at that time. R1 remains in the hospital and upon return will be comprehensively assessed, including being assessed for proper positioning devices needed in wheelchair and shower as indicate Education will be completed with all nursing staff on the Change of Condition, Physician Notification and Occurrence Reporting policies by 8/31/22.	9/8/22

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2 830	Continued From page 3 cognition. R1's activities of daily living (ADL) care plan identified R1 had a self-care performance deficit related to limited range of motion (ROM), contractures, activity intolerance, RA and chronic pain. The care plan directed staff for bathing "I require assist of two using the full lift for transfers and one assist staff participation with bathing." On 8/15/22, the shower chair which R1 was using at the time of the fall was observed stored in the Spa room. The rolling wheeled shower chair was constructed out of Polyvinyl chloride with a straight mesh covered backing and had a blue open front soft vinyl cushion seat with a donut cut out bottom. No safety belts were observed on the chair. The chair could also be used as a commode. Incident Occurrence Report dated 7/28/22, at 10:30 a.m. revealed while in the shower after having the shampoo rinsed out of her hair and was having conditioner put in her hair R1 slipped off the shower chair and fell to the floor. At the time of the fall R1 was being assisted by nursing assistant (NA)-A who witnessed the fall. The staff indicated "Analysis as the cause of occurrence: Poor posture related to [R/T] co-morbidities. Action to Minimize Reoccurrence: Occupational [OT] to evaluate shower chair positioning." During review of the interdisciplinary notes the following was revealed: -Fall description note dated 7/28/22, at 11:38 indicated at 10:30 a.m. while in the shower after having the shampoo rinsed out of her hair and having conditioner put in R1's hair R1 slipped off the shower chair. R1 was being assisted, and the fall was witnessed and due to R1's size and body	2 830	Corrective Action as it Applies to Other Residents: A facility audit of all residents was completed to ensure that they are positioned correctly in their shower chairs to ensure safety during showers. Any positioning concerns will be referred to therapy for evaluation. Reoccurrence will be Prevented by: The Occurrence Reporting Policy and Change of Condition Physician Notification policy were reviewed and remain current. All nursing staff will be re-educated on the Change in Condition Physician Notification policy and Occurrence Reporting policy. The Clinical Administrator and/or designee will conduct bathing audits to ensure proper positioning and safety on 10% of residents weekly for 12 weeks. In addition to bathing audits, weekly Quality assurance meetings will be conducted with the floor staff, Clinical coordinators, Household coordinators and the Clinical administrator and/or Administrator, to identify and ensure any changes in resident conditions are addressed in a timely manner. The Clinical Administrator and/or designee is responsible for ongoing compliance. Audit results will be reported to QAPI team to determine ongoing need for audits.	

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2 830	Continued From page 4	2 830		

alignment, staff was unable to intervene as R1 slipped off the shower chair onto the right side. The note then indicated after the fall R1 rested on the shower room floor on the right side, both knees bent resting on the right shoulder with arm underneath R1. The note also indicated the witness believed R1 did not hit her head but was unable to say for sure. The note then indicated R1's pain was reported as unchanged from prior to the shower. R1 was examined for injury, none noted and then was assisted with four staff and a full body lift into the manual wheelchair, was assisted to her room and into the bed. R1 complained of the right lower extremity (RLE) hurting. The note further indicated the responsible parties, and the nurse practitioner (NP) were notified of the fall and an order was obtained for X-ray to be completed and R1 was noted to have bruising on both knees, left forearm and the left knee there was a 4.0 centimeter (cm) light bruise and skin was intact. The note did not indicate the level of pain R1 had prior to the fall.

-PN dated 7/29/22, at 8:54 a.m. indicated the NP was updated on R1's current status and staff had obtained an order for OT to evaluate and treat, assess cognitive changes as well as shower chair positioning.

-Interdisciplinary team (IDT) follow up analysis PN dated 7/29/22, at 12:34 p.m. indicated R1 had fallen on 7/28/22, at 10:30 a.m. in shower. The noted indicated R1's hair had been washed and rinsed but the body was soapy and was seated "on the shower chair she prefers when showering." The nurse wrote "WAS IT ASSESSED TO BE APPROPRIATE & DEEMED SAFE PRIOR TO FALL? She sat with "her usual abnormal body alignment, head down and leaning to the right at the shoulders. It may be possible

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2 830		2 830		

Continued From page 5

she fell asleep while having her hair washed, leaned forward, and went to the floor. Staff had hands on assist and care plan was followed. She landed on her right side; knees bent. She offered complaints of pain that compared to same pain reported prior to assist with shower per chronic pain noted." The note further indicated R1 had complained of feet hurting. X-ray was ordered. X-ray results noted negative results for fractures on the left foot and ankle, and right foot and ankle. The note did not address and/or respond if the shower chair had been assessed to be appropriate and safe for R1 to use despite R1's "usual abnormal body alignment" and no seat belt.

Progress notes from 7/28/22-8/7/22 revealed documentation of R1 reporting consistent pain, refusing activity and receiving more than average amounts of PRN medication.

The hospital imaging report dated 8/7/22, revealed R1 was found to have the following fractures:
-There are moderate compression fractures of indeterminate age involving the superior L4 and L5 vertebral bodies resulting in increased L3-4 and L4-5-disc height.
- An impacted transverse fracture of the proximal tibial shaft, extending into the tibial plateaus, with mild varus angulation on the left knee.

On 8/15/22, at 1:35 p.m. NA-A stated prior to assisting R1 with the shower on the day R1 fell out of the shower chair, she and another staff had completed the shower the previous week with her observing and doing hands on care (training observation). NA-A stated she and NA-C had transferred R1 into the shower chair and then took R1 into the Spa room where they weighed

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2 830	Continued From page 6	2 830		

Continued From page 6

R1 and then NA-C left her to assist with the shower. NA-A stated after washing and rinsing R1's hair between the shampoo and conditioner she had looked away from R1 to grab the conditioner for R1's hair and in that split second R1 fell out of the shower chair. NA-A stated the distance she had to travel in that split second was approximately a foot length. NA-A stated she was not sure what would have led to the fall to happen but thought it was a combination of R1's abnormal posture and the shower chair being slippery. NA-A stated following the fall she had not received any training but had been involved in discussions on using another shower chair for R1 and using two staff to assist with the bathing. NA-A further stated when R1 was seated on the regular wheelchair she felt R1 did not need help to stabilize, but when in the shower chair NA-A felt she had to hang on to R1 to provide to stabilize her because the chair had an upright back and was not fitted for her abnormal postured like her wheelchair.

During interview on 8/15/22, at 12:50 p.m. the NP stated following the fall her colleague had taken the call regarding R1's fall. NP stated she had then received a call 7/28/22, requesting for an order for OT to evaluate the use of the shower chair and then she returned the call on 7/29/22.

During interview on 8/15/22, at 11:20 a.m. the clinical administrator stated she had been notified about the fall. The CA then stated, "I wish you could see [R1] the big part of this is her posture and she may have shifted." The CA stated since the fall she had been out of the building, however, with briefly discussing about the fall after it happened, the staff thought she could have been slippery from the shower and the shower chair may not be agreeable with her posture as

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2 830	Continued From page 7	2 830		

resident had an abnormal posture issue. When asked if the shower chair had been assessed to be appropriate and safe for R1 to use during shower related to the progression in her disease and posture, the CA stated she could not speak about the chair and knew ??felt??the right size of chair was being used at the time of the fall. The CA directed surveyor to the director of therapy to provide information on when therapy had evaluated R1.

During interview on 8/15/22, at 11:44 a.m. therapy director reviewed the therapy episodes R1 had attended since January 2021 and the medical record lacked documentation of the therapy department evaluating R1's shower chair appropriateness related to R1's postural abnormality. The director of therapy stated due to R1's abnormal posture they had evaluated R1's wheelchair to ensure it was working for R1. The therapy director stated there had not been an assessment done with OT as there was nothing that had been triggered to make them to look at it. The therapy director stated the "preferred shower chair" was something R1 liked and did not want to use the regular tub chair.

During interview on 8/15/22, at 12:19 p.m. the OT stated she had not officially evaluated R1 before the fall in the shower chair but had seen R1 being transported in it in and out of shower, however, nursing had never reported concerns of R1 having positioning problems prior to the fall. OT stated not all residents were evaluated for the shower chairs and nursing would have to make the decision and assess if they had any questions they would seek out to therapy, who would get a referral and order to look into it.

During interview on 8/15/22, at 12:33 p.m. the

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2 830	Continued From page 8 facility administrator stated following the incident the staff involved were given real time education, however, not sure if this was formal education. The administrator further stated no staff education had been implemented following the incident as they felt the staff was doing the correct thing and had followed the care plan. During a follow up interview with the clinical administrator, on 8/16/22, at 9:04 a.m. the CA stated for the shower chair if staff had brought the concern for positioning to management, it would have been assessed and addressed but this never happened and R1 never complained. The CA stated, "Our plan after the fall was for [R1] to be assessed by therapy for safety." The CA acknowledged no assessment had been completed on R1 using the shower chair despite R1's posture changes over time which required other devices to be evaluated by therapy for safety and appropriateness. The CA stated staff education was needed, and she acknowledged R1 had changed, and the appropriateness of the shower chair should have been assessed as R1 was not even the same now in comparison to four months ago. The CA acknowledged R1's posture had changed over time however the shower chair had not been assessed to determine if the shower chair needed a safety belt to provide and secure R1 from falling during showers or to determine if a different shower chair would be appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to accidents and ensuring proper assessment are being conducted for resident care equipment continued use. They could re-educate staff on the policies and procedures. A system for evaluating	2 830		

Minnesota Department of Health

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2 830	Continued From page 9 and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		