Electronically delivered
June 23, 2021

Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, MN 55331

RE: CCN: 245606
Cycle Start Date: June 10, 2021

Dear Administrator:

On June 10, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 10, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by December 10, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/10/2021

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F 000	INITIAL COMMENTS On 6/9/21 to 6/10/21, 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 complaints were found to be SUBSTANTIATED: H5606012C (MN73570), with a deficiency cited at (F760). In addition, during the investigation another deficiency was identified at F609. 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 substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report 2 of 2 incidents of elopement for 1 of 3 residents (R5) reviewed for elopement. In addition, the facility failed to report a significant medication error to the state agency (SA) within 24 hours for 1 of 3 residents (R1) reviewed for medication errors. Findings include: R1's annual Minimum Data Set (MDS), dated 3/16/21, identified R1 as cognitively intact with diagnoses of bipolar disorder and was independent with activities of daily living. R1's care area assessment (CAA), dated 3/16/21, triggered for delirium (inattention and	F 609		

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F 609	Continued From page 2	F 609		

disorganized thinking) and behavioral symptoms related to long-standing mental health problems.

R1's progress note dated 6/5/21, at 10:38 a.m. and identified an incident which occurred at 8:00 a.m. where R1 received another residents medications, became ill with vomiting, increased confusion, and low blood pressure. R1 was sent to the hospital and received IV fluids and was placed on observation over night before being sent back to the facility.

R1's facility reported incident was received at the state agency on 6/6/21, at 11:30 a.m. over 24 hours after the significant medication error was discovered.

R5's quarterly MDS dated 5/27/21, identified R5 as having a severe cognitive impairment with diagnoses of dementia, and required extensive assistance with toileting and person hygiene.

R5's care plan identified R5 had impaired cognitive function, impaired thought processes and long and short term memory deficit as well as having a court appointed guardian as R5 was unable to make safe decisions for himself.

R5's progress note dated 5/7/21, included, a neighbor had called the facility to indicate a resident was stuck on the steps. R5 was found straddling the gait on the back upper deck of the facility. R5 reported he had been there for 2 hours. There was no report to the state agency about this episode.

R5's progress note dated 6/7/21, R5 returned from a walk in wet clothing from the chest down, missing his shoes and bleeding from a laceration

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F 609	Continued From page 3 on his head. R5 was unable to recall where he was or what happened. R5 was sent to the hospital via ambulance. R5's emergency department summary dated 6/7/21, noted R5 had a, "jagged" laceration to his scalp above his hairline that required 3 staples for closure. R5 was discharged the same day and diagnosed with a traumatic injury of the head with laceration and fall. An incident report dated 6/7/21, described R5 as presenting with a laceration to his right forehead and a small abrasion to his left back. R5 was unable to state where his shoes were or how he fell. R5's clothing was also wet and R5 could not explain why. This incident had not been reported to the state agency. When interviewed on 6/10/21, at 9:23 a.m. (DON) stated she did not report the above incidents because she, "did not think of that." The facility Incident / Accident Reporting policy dated 11/1991, noted when a resident falls or in any other way potentially harms themselves, the charge nurse should notify the DON, the attending physician and the residents family or guardian. Further, an incident report must be filled out. There was no requirement listed for staff to notify the State Agency (SA).	F 609		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		

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F 760	Continued From page 4	F 760		

by:
Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1) was free from significant medication errors. This resulted in actual harm for R1 when R1 was administered another resident's medications, experienced adverse medication reactions and received IV fluids and was observed at the hospital overnight with encephalopathy (altered brain function) and hypotension.

Findings include:

R1's annual Minimum Data Set (MDS), dated 3/16/21, included, cognitively intact with diagnoses of depression, anemia and arthritis. R1 was independent with activities of daily living (ADL's).

R1's cognitive loss/dementia care area assessment (CAA), dated 3/16/21, included, delirium (inattention and disorganized thinking) and behavioral symptoms related to long-standing mental health problems.

R1's care plan dated 3/29/21, included, impaired thought processes related to impaired decision making and psychotropic drug use. Staff were directed to: "Administer medications as ordered. Monitor/document for side effects and effectiveness," and to "Monitor/document/report PRN [as needed] any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status."

R1's facility incident report summary, submitted on 6/9/21, at 6:09 p.m. identified a medication

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F 760	Continued From page 5	F 760		

error which occurred on 6/5/21, at 8:00 a.m. "The nurse placed a medication cup on [R1]'s meal tray that belonged to someone else and she immediately took them. When the nurse turned to another resident she realized that she had given [R1] the wrong medications. [R1] finished eating and went up to her room where she felt okay until about 30 minutes later when she vomited and became Somnolent. She was assessed by the nurse and found to have a blood pressure of 79/58 [normal blood pressure 120/60]. 911 was called to take the resident to the hospital for evaluation."

R1's emergency department summary dated 6/6/21, indicated R1 was admitted on 6/5/21, and vitals taken at 9:37 a.m. which noted R1's pulse at 85; respirations at 14 and blood pressure was 93/58. Summary further detailed R1's admission reason: "multi-drug overdose with resulting toxic encephalopathy [affected brain function] and hypotension [low blood pressure]." "[R1] apparently had somehow taken another patient's medicines today. Per the list of the other patient's medicines, [R1] took clozapine [an antipsychotic medication] 150 mg, Trileptal [an anticonvulsant medication] 300 mg, imipramine [an antidepressant] 12.5 mg, Lopressor [a beta blocker to treat high blood pressure] 12.5 mg, levothyroxine [thyroid medication] 125 mcg, tamsulosin [urinary medication used for enlarged prostate] 0.4 mg. [R1] was noted after this ingestion to become more confused as well as hypotensive and was seen by paramedics, treated with IV fluids, and brought to the Emergency Room for further evaluation, where [R1] was initially hypotensive with systolic blood pressures in the 80's. [R1] had subsequently received 1500 ml [milliliters] of normal saline with

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F 760	Continued From page 6	F 760		

blood pressures improving to the low 100 ranges. [R1] is unable to give a good history. [R1] has somewhat slurred speech. Some of [R1] words and some of [R1] responses are appropriate, although others are not. [R1] PCP [primary care provider] is from FV [Fairview] system." R1 was discharged back to the nursing home on 6/6/21.

R2's Medication Administration Record (MAR), identified the following medications for 6/5/21, at 8:00 a.m.
- Tamsulosin HCl Capsule: Give 0.4 mg by mouth two times a day;
- Senna [laxative] Tablet 8.6 MG (Sennosides): Give 2 tablet by mouth two times a day;
- Lopressor Tablet (Metoprolol Tartrate): Give 12.5 mg by mouth two times a day;
- Trileptal Tablet (OXcarbazepine): Give 300 mg by mouth one time a day;
- Levothyroxine Sodium Tablet: Give 125 mcg by mouth one time a day every Mon, Tue, Wed, Fri, Sat;
- Imipramine HCl Tablet: Give 12.5 mg orally one time a day, Take 12.5mg in the morning;
- Folic Acid Tablet 400 MCG: Give 1 tablet by mouth one time a day;
- Cyanocobalamin Tablet: Give 1000 mcg by mouth one time a day;
- cloZAPine Tablet: Give 150 mg by mouth one time a day and
- Cholecalciferol Tablet: Give 2000 unit by mouth one time a day.

When interviewed on 6/9/21, at 9:48 a.m. R1 stated, "I got the wrong pills. I was eating breakfast and she [RN-A] left the wrong ones and I didn't look at the cup." "I remember going upstairs then I sat on the stairs, and I woke up in the hospital," "I was there [at the facility] Saturday

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F 760	Continued From page 7	F 760		

morning at 8:30 a.m. then I woke up at 2:00 p.m." "The meds took effect real fast - they gave me my medications too and that didn't really help." R1 further recalled vomiting when she got back up to her room.

When interviewed on 6/9/21, at 10:27 a.m. registered nurse (RN)-A stated on the morning of 6/5/21, there was a change in the dining room seating arrangements for the residents which caused atypical commotion during morning medication pass. It is usual procedure to set up several resident's medications in advance, place them in medication cups tabled with the resident name and bring them all to the dining room at once to administer them. RN-A stated, "I remember walking to another resident, and I didn't have her meds then I said to [R1], don't take them." RN-A noted it was too late and observed R1 had taken her morning medications along with another resident's a.m. medications. RN-A added, "I gave it to her in error and as soon as I realized the mistake, I sent a text to the director of nursing (DON) and called the on-call medical doctor, described all the medications administered in error and called 911 and R1 was sent to hospital." RN-A added she could not remember if R1 had eaten her breakfast that morning or not, however noted R1 vomited roughly 20 minutes after ingesting her own and R2's of medications.

R1's Medication Administration Record (MAR) identified R1's medications she had also received on 6/5/21, at 8:00 a.m. as a multivitamin, vitamin D, Olanzapine (an antipsychotic), a laxative, Sertraline (an antidepressant), valacyclovir (antiviral) and acetaminophen.

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F 760	Continued From page 8 When interviewed on 6/9/21, at 10:46 a.m. nursing assistant (NA)-A stated after breakfast RN-A told NA-A to go upstairs and have R1 come back down to the main floor. NA-A attempted to have R1 walk down the stairs but was R1 was unable to stand, she was drooling and was not making sense, she was limp and weak. NA-A and RN-a had to provide extensive assist to R1 to get to the first level of the home. NA-A and RN-a assisted R1 into a wheelchair and checked R1's blood pressure and it was very low, 70/50. R1's Weights and Vitals Summary report from 3/6/21 through 6/5/21, identified R1 did have blood pressures in the range of 72/55 to 129/70, and lower than normal (120/80) blood pressures were not unusual for her. When interviewed on 6/10/21, at 8:38 a.m. Sterling pharmacist stated the medications administered in error can cause a person to be sedated and to lower their blood pressure. Pharmacist further stated the administration of Clozapine can cause cardiovascular side effects such as tachycardia (fast heart rate). The pharmacist stated it was fortunate R1 had vomited shortly after taking them. When interviewed on 6/9/21, at 1:18 p.m. the DON stated she had been notified by RN-A via text message of the medication error RN-A administered to R1 the morning of 6/5/21. DON stated the facility practice was to set-up of medications for two residents at a time moments before staff administer the medication to the residents. DON added, "Yes and this is an acceptable practice here." DON further presented a tray with the names of the all the residents to corroborate the facilities' accepted use of	F 760		

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F 760	Continued From page 9	F 760		

prepping several resident medications at a time, prior administration.

R1's late entry progress note dated 6/5/21, at 10:38 a.m. described, "At 0800 [8:00 a.m.] this morning [R1] took her medication, which I (RN-A) provided her with. While this writer was passing other medications and approaching another resident, [R2] I (RN-A) noticed that R2's medication cup was missing. [RN-A] turned around and saw the empty medication cup on R1's tray. Time lapse was ~ 10 second, but R1 had taken R2's medication. There was a lot of activity going on the Day Room, e.g., additional residents waiting for the next seating, questions from multiple individuals asking about the new seating arrangement, requests for timing of next PRN [as needed] medications, etc. so this writer was distracted by the activity. Although I (RN-A) don't recall giving R1's, R2's medications specifically, I (RN-A) am assuming I (RN-A) placed R2's medication cup on R1's tray on error, since helping herself to her own medications is not something I (RN-A) am aware of R1 ever doing. I (RN-A) notified the DON of the above at 0813 [8:13 a.m.]. I (RN-A) called R1's MD [medical doctor] at Bethesda Medical at 0820 [8:20 a.m.]. The on-call MD [medical doctor] returned the call at 0840 [8:40 a.m.] with instructions to send R1 into the ER. I (RN-A) called 911 as soon as I (RN-A) completed the MD [medical doctor] call at ~0845 [8:45 a.m.]. The Deephaven Police arrived ~0850 [8:50 a.m.] and the ambulance arrived at ~0900 [9:00 a.m.]; departing at 0905 [9:05 a.m.] V.S. [vital signs] at the time of departure were: T [temperature] 97.3; R [respirations] 24; O2 [oxygen saturation] 94%; P [pulse] 93 and BP [blood pressure] 79/58. At 10:30, I called Methodist ER for a update on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/10/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 10 [R1]'s condition and was told she is sleeping; BP [blood pressure] remains at 80/60." The facility policy titled, Medication Administration, dated 6/2021, detailed: Policy: To administer resident's medications in accordance with doctor's orders. Procedure: 1. Nursing staff will wash hands before administering medication. 2. EMAR will be used to dispense correct medications. 3. Obtain medication from the cart with the correct resident utilizing the correct color sticker for the current administration time. 4. Medication should be dispensed into med cup after observing the resident's name on the medication card, the correct medication corresponding with the EMAR, the correct dose and the right route. 5. Medication will be given directly to resident with nurse observing that the resident takes all of the medication. 6. Medication is signed off in the EMAR as having been given immediately after dispensing.	F 760		

Electronically delivered
June 23, 2021

Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, MN 55331

Re: State Nursing Home Licensing Orders
Event ID: WO1Y11

Dear Administrator:

The above facility was surveyed on June 9, 2021 through June 10, 2021 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:

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 6/9/21 to 6/10/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be 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	2 000		

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2 000	Continued From page 1 be completed. The following complaint was found to be SUBSTANTIATED: H5606012C (MN73570) with a licensing order issued at 1545. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation	21545		

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21545	Continued From page 3 must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1) was free from significant medication errors. This resulted in actual harm for R1 when R1 was administered another resident's medications, experienced adverse medication reactions and received IV fluids and was observed at the hospital overnight with encephalopathy (altered brain function) and hypotension. Findings include: R1's annual Minimum Data Set (MDS), dated 3/16/21, included, cognitively intact with diagnoses of depression, anemia and arthritis. R1 was independent with activities of daily living (ADL's). R1's cognitive loss/dementia care area assessment (CAA), dated 3/16/21, included, delirium (inattention and disorganized thinking) and behavioral symptoms related to long-standing mental health problems. R1's care plan dated 3/29/21, included, impaired	21545		

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21545	Continued From page 4	21545		

thought processes related to impaired decision making and psychotropic drug use. Staff were directed to: "Administer medications as ordered. Monitor/document for side effects and effectiveness," and to "Monitor/document/report PRN [as needed] any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status."

R1's facility incident report summary, submitted on 6/9/21, at 6:09 p.m. identified a medication error which occurred on 6/5/21, at 8:00 a.m. "The nurse placed a medication cup on [R1]'s meal tray that belonged to someone else and she immediately took them. When the nurse turned to another resident she realized that she had given [R1] the wrong medications. [R1] finished eating and went up to her room where she felt okay until about 30 minutes later when she vomited and became Somnolent. She was assessed by the nurse and found to have a blood pressure of 79/58 [normal blood pressure 120/60]. 911 was called to take the resident to the hospital for evaluation."

R1's emergency department summary dated 6/6/21, indicated R1 was admitted on 6/5/21, and vitals taken at 9:37 a.m. which noted R1's pulse at 85; respirations at 14 and blood pressure was 93/58. Summary further detailed R1's admission reason: "multi-drug overdose with resulting toxic encephalopathy [affected brain function] and hypotension [low blood pressure]." "[R1] apparently had somehow taken another patient's medicines today. Per the list of the other patient's medicines, [R1] took clozapine [an antipsychotic medication] 150 mg, Trileptal [an anticonvulsant medication] 300 mg, imipramine [an

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21545	Continued From page 5	21545		

antidepressant] 12.5 mg, Lopressor [a beta blocker to treat high blood pressure] 12.5 mg, levothyroxine [thyroid medication] 125 mcg, tamsulosin [urinary medication used for enlarged prostate] 0.4 mg. [R1] was noted after this ingestion to become more confused as well as hypotensive and was seen by paramedics, treated with IV fluids, and brought to the Emergency Room for further evaluation, where [R1] was initially hypotensive with systolic blood pressures in the 80's. [R1] had subsequently received 1500 ml [milliliters] of normal saline with blood pressures improving to the low 100 ranges. [R1] is unable to give a good history. [R1] has somewhat slurred speech. Some of [R1] words and some of [R1] responses are appropriate, although others are not. [R1] PCP [primary care provider] is from FV [Fairview] system." R1 was discharged back to the nursing home on 6/6/21.

R2's Medication Administration Record (MAR), identified the following medications for 6/5/21, at 8:00 a.m.
- Tamsulosin HCl Capsule: Give 0.4 mg by mouth two times a day;
- Senna [laxative] Tablet 8.6 MG (Sennosides): Give 2 tablet by mouth two times a day;
- Lopressor Tablet (Metoprolol Tartrate): Give 12.5 mg by mouth two times a day;
- Trileptal Tablet (OXcarbazepine): Give 300 mg by mouth one time a day;
- Levothyroxine Sodium Tablet: Give 125 mcg by mouth one time a day every Mon, Tue, Wed, Fri, Sat;
- Imipramine HCl Tablet: Give 12.5 mg orally one time a day, Take 12.5mg in the morning;
- Folic Acid Tablet 400 MCG: Give 1 tablet by mouth one time a day;
- Cyanocobalamin Tablet: Give 1000 mcg by mouth one time a day;

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21545	Continued From page 6 - cloZAPine Tablet: Give 150 mg by mouth one time a day and - Cholecalciferol Tablet: Give 2000 unit by mouth one time a day. When interviewed on 6/9/21, at 9:48 a.m. R1 stated, "I got the wrong pills. I was eating breakfast and she [RN-A] left the wrong ones and I didn't look at the cup." "I remember going upstairs then I sat on the stairs, and I woke up in the hospital," "I was there [at the facility] Saturday morning at 8:30 a.m. then I woke up at 2:00 p.m." "The meds took effect real fast - they gave me my medications too and that didn't really help." R1 further recalled vomiting when she got back up to her room. When interviewed on 6/9/21, at 10:27 a.m. registered nurse (RN)-A stated on the morning of 6/5/21, there was a change in the dining room seating arrangements for the residents which caused atypical commotion during morning medication pass. It is usual procedure to set up several resident's medications in advance, place them in medication cups tabled with the resident name and bring them all to the dining room at once to administer them. RN-A stated, "I remember walking to another resident, and I didn't have her meds then I said to [R1], don't take them." RN-A noted it was too late and observed R1 had taken her morning medications along with another resident's a.m. medications. RN-A added, "I gave it to her in error and as soon as I realized the mistake, I sent a text to the director of nursing (DON) and called the on-call medical doctor, described all the medications administered in error and called 911 and R1 was sent to hospital." RN-A added she could not remember if R1 had eaten her breakfast that morning or not, however noted R1 vomited	21545		

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21545	Continued From page 7 roughly 20 minutes after ingesting her own and R2's of medications. R1's Medication Administration Record (MAR) identified R1's medications she had also received on 6/5/21, at 8:00 a.m. as a multivitamin, vitamin D, Olanzapine (an antipsychotic), a laxative, Sertraline (an antidepressant), valacyclovir (antiviral) and acetaminophen. When interviewed on 6/9/21, at 10:46 a.m. nursing assistant (NA)-A stated after breakfast RN-A told NA-A to go upstairs and have R1 come back down to the main floor. NA-A attempted to have R1 walk down the stairs but was R1 was unable to stand, she was drooling and was not making sense, she was limp and weak. NA-A and RN-a had to provide extensive assist to R1 to get to the first level of the home. NA-A and RN-a assisted R1 into a wheelchair and checked R1's blood pressure and it was very low, 70/50. R1's Weights and Vitals Summary report from 3/6/21 through 6/5/21, identified R1 did have blood pressures in the range of 72/55 to 129/70, and lower than normal (120/80) blood pressures were not unusual for her. When interviewed on 6/10/21, at 8:38 a.m. Sterling pharmacist stated the medications administered in error can cause a person to be sedated and to lower their blood pressure. Pharmacist further stated the administration of Clozapine can cause cardiovascular side effects such as tachycardia (fast heart rate). The pharmacist stated it was fortunate R1 had vomited shortly after taking them. When interviewed on 6/9/21, at 1:18 p.m. the DON stated she had been notified by RN-A via	21545		

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21545	Continued From page 8	21545		

text message of the medication error RN-A administered to R1 the morning of 6/5/21. DON stated the facility practice was to set-up of medications for two residents at a time moments before staff administer the medication to the residents. DON added, "Yes and this is an acceptable practice here." DON further presented a tray with the names of the all the residents to corroborate the facilities' accepted use of prepping several resident medications at a time, prior administration.

R1's late entry progress note dated 6/5/21, at 10:38 a.m. described, "At 0800 [8:00 a.m.] this morning [R1] took her medication, which I (RN-A) provided her with. While this writer was passing other medications and approaching another resident, [R2] I (RN-A) noticed that R2's medication cup was missing. [RN-A] turned around and saw the empty medication cup on R1's tray. Time lapse was ~ 10 second, but R1 had taken R2's medication. There was a lot of activity going on the Day Room, e.g., additional residents waiting for the next seating, questions from multiple individuals asking about the new seating arrangement, requests for timing of next PRN [as needed] medications, etc. so this writer was distracted by the activity. Although I (RN-A) don't recall giving R1's, R2's medications specifically, I (RN-A) am assuming I (RN-A) placed R2's medication cup on R1's tray on error, since helping herself to her own medications is not something I (RN-A) am aware of R1 ever doing. I (RN-A) notified the DON of the above at 0813 [8:13 a.m.]. I (RN-A) called R1's MD [medical doctor] at Bethesda Medical at 0820 [8:20 a.m.]. The on-call MD [medical doctor] returned the call at 0840 [8:40 a.m.] with instructions to send R1 into the ER. I (RN-A) called 911 as soon as I (RN-A) completed the MD

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LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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21545	Continued From page 9 [medical doctor] call at ~0845 [8:45 a.m.]. The Deephaven Police arrived ~0850 [8:50 a.m.] and the ambulance arrived at ~0900 [9:00 a.m.]; departing at 0905 [9:05 a.m.] V.S. [vital signs] at the time of departure were: T [temperature] 97.3; R [respirations] 24; O2 [oxygen saturation] 94%; P [pulse] 93 and BP [blood pressure] 79/58. At 10:30, I called Methodist ER for a update on [R1]'s condition and was told she is sleeping; BP [blood pressure] remains at 80/60." The facility policy titled, Medication Administration, dated 6/2021, detailed: Policy: To administer resident's medications in accordance with doctor's orders. Procedure: 1. Nursing staff will wash hands before administering medication. 2. EMAR will be used to dispense correct medications. 3. Obtain medication from the cart with the correct resident utilizing the correct color sticker for the current administration time. 4. Medication should be dispensed into med cup after observing the resident's name on the medication card, the correct medication corresponding with the EMAR, the correct dose and the right route. 5. Medication will be given directly to resident with nurse observing that the resident takes all of the medication. 6. Medication is signed off in the EMAR as having been given immediately after dispensing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21545	Continued From page 10 medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		