Electronically delivered
July 1, 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 23, 2021, we informed you we may impose enforcement remedies.

On June 18, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. remove this sentence if not SQC and IJ. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 18, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 16, 2021.

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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 16, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 16, 2021.

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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lake Minnetonka Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 18, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

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

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

DEPARTMENT CONTACT

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

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 - 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 December 10, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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/ 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 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

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

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	245606	A. BUILDING _____ B. WING _____	C 06/18/2021

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LAKE MINNETONKA CARE CENTER	**20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331**

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F 000	INITIAL COMMENTS	F 000		

On 6/15/21, 6/16/21, 6/17/21 and 6/18/21 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:

H5606013C (MN73799), with deficiencies cited at F568 and F744.
H5606014C (MN73798), with deficiencies cited at F689.
H5606015C (MN73796), with deficiencies cited at F689.

The survey resulted in an Immediate Jeopardy (IJ) at F689 when R1 eloped from the facility, suffered a laceration to head and required emergency medical services. The IJ began on 5/9/21, and the immediacy was removed on 6/18/21.

The above findings constituted substandard quality of care, and an extended survey was conducted from 6/17/21 to 6/18/21.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance.

Please email you POC to:
Karen.Aldinger@state.mn.us
651-201-3794

Upon receipt of an acceptable POC, an onsite

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

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F 000	Continued From page 1 revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an appropriate accounting of resident funds was documented and funds used as directed by the resident in a timely fashion for 1 of 1 residents reviewed for facility fiduciary responsibility of personal funds (R2). Findings include: R2's MDS, dated 4/24/21, revealed R2 had moderate cognitive impairment and hallucinations and delusions. R2 had a diagnosis of Schizoaffective disorder and dementia. On 6/17/21, at 3:59 p.m. licensed practical nurse, (LPN)-C, reported R2 would give RN-B money for a coffee from a specialty coffee shop. RN-B said	F 568		

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R2 would wait for RN-B's car to come in and ask if she had her coffee, to which RN-B would respond, "does it look like I have coffee in my hand?" LPN-C reported RN-B verbally acknowledged she was entrusted with R2's money for coffee and would make using the funds for coffee contingent upon R2's behavior, R2 following her toileting program and R2 not irritating RN-B. LPN-C reported she witnessed these exchanges between RN-B and R2 on multiple occasions, as recent as May 2021. R2 would talk to LPN-C over the night time about how she had given RN-B money and she hoped she would get her coffee the next morning. LPN-C reported she did not think RN-B ultimately kept R2's money for her own gain but felt she staff should not take money and RN-B should not have waited an extended time period to get R2 her coffee with her own funds. LPN-C reported to her knowledge, it was not part of R2's care plan to have use of her own funds used to buy coffee, contingent upon her behavior. LPN-C reported she had reported her concerns to the director of nursing (DON). DON told LPN-C it was not a concern as the coffee eventually got purchased. LPN-C reported R2 was vulnerable from a mental and social standpoint as she wanted others to like her did not want to get anyone in trouble and had previously been exploited by her peers.

R2's care plan, intervention, dated 2/17/21, directed staff, "Staff may provide [R2] incentives to remain dry during outings or in the facility." The care plan did not direct staff to take money from R2 and then making her use of that money for the purchase of coffee dependent on compliance with her toileting program.

R2's resident's personal account ledger, dated

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November 2020 through June 17th 2021, was last updated on 6/1/21. The ledger indicated no accounting that RN-B had accepted money entrusted to her by R2 and no evidence RN-B had purchased coffee for R2 using R2's funds.

On 6/17/21, at 3:19 p.m., a registered nurse (RN)-B reported she previously held funds given to her by R2 for the purposes of purchasing a coffee from a specialty coffee shop. RN-B reported R2 would give her $5 on occasion. RN-B added that she would purchase R2's coffee for her, contingent upon compliance with toileting program. RN-B told R2 she would keep the money for a week before purchasing her coffee. RN-B reported there was no system to account for the money entrusted to her by R2.

On 6/16/21 at 11:00 a.m. DON reported RN-B would take money from R2 to get her coffee. There was no system to document the exchange of money and goods between RN-B and R2. RN-B reported she was not concerned about residents entrusting staff with money to purchase goods for them.

An email from DON, dated 6/17/21, indicated, "I will let you know that I know personally that [RN-B] provided the coffee for [R2]. [RN-B] and I used to ride together and we always work on the same days during the week and I can recall the day that [RN-B] said that she brought her Coffee. [RN-B] had told her that when she goes to get coffee that she would provide it to her but that she didn't know exactly when that would be. Therefore when we were bringing coffee from home for ourselves we were not "buying" coffee for her. I have found that [R2's] claims were unsubstantiated because I know that she was

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provided with the coffee that she paid for, just not immediately. Staff will no longer be accepting money from residents directly unless it is for the pop machine outside of the building that they are not able to utilize themselves d/t mobility issues. Unfortunately we are just not going to be able to provide this service to them as we have in good faith in the past."

The Resident Purchases Policy, dated June 2021, directed staff, " Policy: Staff (typically activity director [AD] or administrative assistant [AA], on occasion other staff may "pick something up") may assist resident with purchases, especially when the resident is unable to shop for themselves. Procedure:1. Resident or resident's guardian will inform staff of a need or want to purchase an item. AD shops at Walmart or Target once or twice a month. AD visits with residents to inquire if they would like to make a list of items to be purchased. 2. AD or AA will research the item(s) needed online or in a catalog and discuss with the resident 3. Once an item(s) is agreed upon by the resident or their guardian, the AD or AA will order online or go to a store to make the purchase. 4. AD or AA will keep the resident informed when to expect their purchase. Sometimes the resident may need gentle reminders that shipping is out of our control. 5. After the resident receives the purchase, if it is clothing and fits, staff will write with permanent marker the resident initials on an interior label. 6. AD or AA will submit the receipt to the administrative office for reimbursement through the resident account by issue of a check. 7. In order to alleviate confusion, staff is not to take cash from a resident except if the resident wants a pop from the pop machine and is unable to ambulate outside to access the machine. 8. All

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F 568	Continued From page 5 purchases are to be reimbursed through the resident account checkbook upon presentation of a receipt."	F 568		
F 689 SS=J	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 assess safety risk for 1 of 3 residents (R5) who were allowed to go into the community unsupervised, which placed R5 at risk for serious injury, impairment or death. R5 returned to the facility, which was located a block and half from a lake, wet from the chest down, had a head laceration which required emergency room care for staples, and was missing his shoes. In addition to the resident in immediate jeopardy, the facility failed to ensure the porch and deck area were free of potential accident hazards for 3 of 3 (R12, R5 and R2) who were on the deck area while decking boards were being removed which had the potential for harm that is not immediate jeopardy. The immediate jeopardy began on 5/9/21, when R5 attempted to climb over a gate on the 2nd floor of an outside deck, was unable to free himself from the gate, and the facility failed to assess R5 for safely leaving the facility	F 689		

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independently. Subsequently on 6/9/21, R5 had returned from an unknown location to the facility wet from the chest down and with a head laceration. The immediate jeopardy was identified on 6/16/21. The director of nursing (DON) and administrator were notified of the immediate jeopardy (IJ) on 6/16/21, at 3:16 p.m. The immediate jeopardy was removed on 6/18/21, but noncompliance remained at the lower scope and severity level of a D- isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R5's quarterly Minimum Data Set (MDS) dated 5/27/21, included severe cognitive impairment with diagnoses including dementia and Parkinson's disease. R5 had signs and symptoms of delirium including inattention and disorganized thinking that fluctuated, and also had hallucinations and delusions. R5 required supervision and oversight for transfers and ambulation and the assistance of one person. R5 had 2 or more falls since the prior assessment.

R5's cognitive loss/dementia Care Area Assessment (CAA) dated 8/24/20, included, R5 required more assistance with cares, had difficulty completing tasks, and had impaired daily decision making skills such as choosing to wear inappropriate clothing for the weather. R5's falls CAA dated 8/24/20, identified risk for falling and had 3 falls from attempting to sit in a chair and did not safely judge how he could do so safely.

R5's care plan dated 2/12/21, identified, "has impaired cognitive function/dementia or impaired

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F 689	Continued From page 7 thought processes r/t [related to] Dementia, impaired decision making, long term memory loss, short term memory loss." R5's care plan included interventions: "Cue, reorient and supervise as needed, remind [R5] to always let staff know where he is going when he goes for a walk, make sure he is dressed appropriately and is appropriate at the time for independence outside of the facility." A written note dated 5/9/21, indicated R5 attempted to leave without notice via the upper deck and sustained an injury and the new intervention indicated, "new door alarm installed on upstairs emergency exit." R5's care plan further detailed R5 as having a court appointed guardian as R5 was unable to make safe decisions for himself. R5's care plan also identified the risk for falls detailing, "R5 is high risk for falls r/t confusion, gait/balance problems, medications, lack of safety awareness and Parkinson's Disease," with hand written notation dated 5/9/21: "needs ^ [increased] supervised 30 min checks, " and "[R5] will be supervised by staff." Followed by note dated 5/19/21, "Staff will assist him when sitting in a chair in dayroom." R5's progress note dated 5/9/21, at 11:43 a.m. indicated the facility received a phone call from a neighbor, "someone was stuck on the steps." R5 was found straddling a gait from the back upper deck of the facility. R5 reported he had been there for 2 hours, he had blood running down his leg and reported to staff that he had been bitten, "by weasels." Facility staff assisted R5 into the home but he was too weak and shaking to assist to the main level of home. Staff left R5 seated on the bed while she went to get supplies to assist to clean area on leg and when she returned R5 was on the floor bleeding from his head. R5 was sent to the hospital via ambulance.	F 689		

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R5's facility fall/incident report dated 5/9/21, at 5:30 a.m. described R5's incident, "fall and attempt to leave," location of incident noted, "bedroom and upper deck." Nursing notes section further detailed, "resident was discovered on upper deck attempting to climb over gate. He had small laceration on his leg and toe. Returned to his bedroom he then fell and hit his face, lacerations above left eye sustained - 911 called and he was sent in." The report detailed R5 has a history of falls and impaired safety awareness/judgement, as well as dementia and Parkinson's disease.

R5's Fall Risk Assessment dated 5/9/21, identified R5 was at high risk for falls and had 3 or more falls in the past 3 months, had intermittent confusion, vision was poor, and had a balance problem while ambulating, Even though R5 was at high risk for falls, he had not been assessed for safety while going for walks in the community independently.

R5's progress note dated 5/16/21, indicated his gait was, "off," and was leaning to the side.

R5's Fall Risk Assessment dated 5/19/21 identified R5 was at high risk for falling due to confusion, poor vision, balance problem while standing and ambulating, medication use and predisposing conditions. Even though R5 was at high risk for falls, he had not been assessed for safety in going for walks in the community independently.

R5's progress note dated 5/20/21, identified he required extensive assistance with transfer and ambulation and was leaning to the left. However,

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he had not been assessed for safety in going into the community without supervision and his care plan had not been updated.

R5's late entry progress note dated 6/7/21, at 6:32 p.m. indicated R5 returned from a walk in wet clothing from the chest down, missing his shoes and bleeding from a laceration on his head. R5 was unable to recall where he was or what happened. R5 was sent to the hospital via ambulance.

R5's facility fall/incident report dated 6/7/21, at unknown evening time, described R5's incident as a, "mechanical fall" location outside. "Res [resident] presents with a laceration to R [right] forehead, small abrasion to L [left] back and no shoes on. Res unable to state where his shoes are or how he fell, agreeable to every suggestion. Laceration continues to ooze blood so he was sent via ambulance to Methodist for evaluation. Residents clothing was also wet and he could not explain why." Lake Minnetonka, a large body of water, was located within a block and a half of the facility.

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.

The facilities nurse communication log book, dated 6/14/21, directed staff: "[R5] is no longer allowed to go outside for walks without staff supervision." R5 did not have an assessment and his care plan had not been updated.

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When interviewed on 6/15/21, at 1:05 p.m. nursing assistant (NA)-C stated R5 is able to go for walks without supervision as long as he is properly dressed for the weather. NA-C stated she was aware of R5's recent falls and the incidents on 5/9/21 and 6/7/21, however, there were no new interventions and R5 was still able to go for walks unsupervised.

On 6/15/21, at 3:13 p.m. NA-B stated R5 was allowed to go out on walks by himself, he was unsteady and had memory problems, but was not aware of any new guidance for him. Staff typically checked on R5 at beginning of shift, at meal times and when offering him assistance with toileting every couple of hours. There was an alarm on the doors and staff tried to see who went out when it would alarm.

On 6/15/21 at 3:33 p.m. registered nurse (RN)-A, stated R5 was resistant to redirection for cares, would wear clothing inappropriate for the weather, walked with a shuffling gait and had a propensity for falls. R5's cognitive ability was variable, and would ask nonsensical questions and was unable to make decisions for himself. However, R5 was allowed to sign out and leave the building on his own. R5 liked to walk down the road watch the construction workers, he may sit in a swing in the yard. RN-A stated one time R5 was lost in the community and someone brought him back. If there were any concerns for R5's location, the local police department would likely find him and bring him back, as the local police were familiar with the facility residents. R5 had previously worn a GPS unit, but that had been discontinued because R5 would remove it. RN-A had never completed an elopement or safety assessment for R5. RN-A was not aware of any new

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F 689	Continued From page 11 interventions for R5. On 6/15/21, at 4:15 p.m. the activity director (AD) reported R5 would previously swing in the yard and walked to watch the construction workers at a nearby site in the neighborhood on his own, without staff supervision. AD reported R5 had problems a couple times recently and was now not able to go out on his own. AD explained the door bell would go off when staff, residents or visitors entered or exited the building. When it rang, staff were supposed to check and see who was entering or exiting and redirect if the resident was not safe to go outside on his own. AD explained R5 did not have shoes. AD described she was working in the kitchen one evening when R5 returned from the community and was wet, had no shoes on and had a cut on his forehead. AD explained R5 was supposed to sign out, but had noted R5 had not signed out that day. AD explained R5's pants were wet and thought R5 might have walked to a nearby public beach, approximately one block away, took his shoes off and walked in the sand. R5 was not able to articulate where he had gone. R5 had returned wearing a pair of jogging pants and a t-shirt. R5 was gone for about an hour. AD reported the DON told her that night that R5 could no longer go outside on his own. AD reported R5 took direction well, but was "hard headed" at times, was sometimes forgetful of where he placed belongings and would get anxious and would require staff redirection as he wore multiple coats while it was hot outside and winter boots while walking up and down the stairs at the facility. When interviewed on 6/15/21, at 1:33 p.m. licensed practical nurse (LPN)-A stated "I would not let him out on my shift unless he goes with	F 689		

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staff, his cognition is hit or miss, along with his medications that have changed, his speech pattern difficult to understand him," and indicated overall R5 was not safe out in the community without supervision. LPN-A stated R5 used to have a GPS tracking device, but it was on hold and did not know why. R5 was supposed to sign out when he would leave for a walk, but often forgot due to his dementia.

The Lake Minnetonka Care Center May/June 2021, Release of Responsibility for Leave of Absence sign out form failed to identify R5 had signed out to go for a walk at all on 6/7/21.

When interviewed on 6/16/21, at 8:27 a.m. Director of Nursing (DON) stated, on 6/7/21, R5 had still been allowed to go out for walks unsupervised, she did not feel he was an elopement risk as he had always come back to the facility, even though he has severe cognitive impairment, delusions and Parkinson's disease and had fallen many times. The DON stated in the past, community members had brought R5 back to the facility and if he fell while out on a walk, a community member would help or the police would. R5 used to wear a GPS watch, but it was stopped as R5 would normally just stay on the road the facility was located on. R5 was supposed to sign out each time he went for a walk, however, often would forget and did not sign out on 6/7/21. On 6/7/21, they did not know how long he had been gone, or where he had walked to, R5 returned to the facility with a head injury, had dirt and leaves in his beard and was wet. R5 stated he had fallen into rocks while walking up a hill. The DON stated they gave R5 a shower as they did not know why he was wet, but assumed it could have been from a sprinkler

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F 689	Continued From page 13 system in the community. When interviewed on 6/16/21, at 10:49 a.m. Psychiatric Nurse Practitioner (NP)-E stated, R5 should not go for walks in the neighborhood alone due to his balance issues, psychosis and dementia. When interviewed on 6/17/21, at 9:10 p.m. R5's primary physician (PCP) stated the situation of R5 walking around the neighborhood unsupervised did not come up during his visits with R5, but was aware R5 had recent falls. PCP stated with R5's most recent falls he had concerns related to the disease process of R5's Parkinson effecting his mobility, as well as R5's overall cognitive functioning. PCP further added after the 6/7/21 fall that R5 "not be advised to go out in community without supervision again." During observation on 6/16/21, at 12:30 p.m. with the administrator the following was observed: On the second floor there was a door open to a small deck leading to a set of several stairs. At the top of the stairs there was a worn and weathered wooden gate that was the width of the stairs and about 3 feet in length, that reached to approximately 4 feet off the ground. There were sticks and leaves on the deck. This had been the deck and gait R5 had been trapped in on 5/9/21. The administrator stated the gait had not been assessed for safety before or after R5's incident. When interviewed on 6/16/21, at 2:52 p.m. R5's legal guardian (LG) stated he was unaware if R5 was allowed to walk around in the neighborhood without staff supervision and had assumed staff were present, but was aware R5 walked the grounds of the facility. Guardian stated, "I would	F 689		

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F 689	Continued From page 14 not favor R5 walking around in the community." A facility policy titled, Elopement/Wandering Policy, dated 05/2020, included: Lake Minnetonka Care Center (LMCC) will assess for elopement/wandering concerns upon admission to our facility. Proper training will be given to all employees regarding the monitoring and handling of such residents who may be at risk. Procedure: 1. LMCC's Director of Nursing will assess residents for elopement/wandering. concerns upon admission to our facility. Quarterly assessments will be completed thereafter. For residents that have been identified at high risk, monthly assessments will be completed. All staff will be made aware of at risk residents. 2. Resident care plans will list interventions being used for wandering/elopement. 3. Staff are to document wandering in Target Behavior book. 5. Proper training will be given to all employees regarding the monitoring and handling of residents who may be at risk. 6. Training will include but not be limited to routine room checks, door alarm procedures, GPS watch monitoring (if applicable), and general resident demeanor (signs/triggers for possible elopement escalation). 9. In the event a resident appears to have eloped, all staff on duty will be alerted and will assist with immediately checking the facility and grounds along with the local neighborhood. If unable to locate resident, Charge Nurse will contact the local police and report a missing person. 10. The Charge Nurse will then contact the Administrator and Director of Nursing. 11. Either the Administrator or Director of Nursing	F 689		

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F 689	Continued From page 15 will file a Vulnerable Adult report online. 14. Upon location of the resident, an assessment will be completed as to the physical, emotional and mental well-being of the resident to determine if hospitalization is required. 15. Staff will discuss the situation to evaluate what happened and how this could be avoided/handled if a future situation were to occur. 16. Reports will be completed and all parties notified. 17. Close monitoring of the residents' whereabouts and demeanor will be a priority. The immediate jeopardy which began on 5/9/21, was removed on 6/18/21, at 12:13 p.m. when it was verified through record review the facility had completed a Wandering Risk Assessment and Wandering Risk Scale for R5, R5's care plan was updated to include R5's legal guardian or staff were now required to accompany him to all appointments and outings. An Angel Sense monitor, which is a GPS tracking device had been ordered and verified by FedEx to arrive on 6/18/21. Until then, staff were to be alert for R5 exiting the facility via the door alarms, this was verified by documentation of education and staff interviews with RN-B, LPN-B, NA-A, NA-C and NA-D. R5 was to have 30 minute checks which were being signed out by staff as completed. The facility had also completed Wandering Risk Assessments on all facility residents. It was determined 10 residents (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11) were unsafe to leave the facility independently, other than the deck. The list of residents was placed in the office nursing staff use, in the kitchen and utility room. Each residents care plan was updated to reflect this. Education sign in sheets indicated all staff	F 689		

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F 689	Continued From page 16 working had been educated on the elopement policy, residents who were unsafe to leave the facility independently, training on the door alarms and 30 minute checks was provided. Staff had been alerted they were required to attend this training prior to starting their next shift. This was verified by staff interview on 6/18/21, between 9:00 a.m. and 12:00 p.m. However, noncompliance remained at the lower scope and severity level of a D- isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy, because R5's sensor had not arrived yet and continued education was required. R12's MDS dated 3/23/21, included, cognitively intact and had impaired vision. R12 required supervision with walking in corridor and was not steady, but able to steady without human assistance while walking. R2's MDS dated 4/24/21, included, moderate cognitive impairment, required extensive assistance of one person for walking in corridor. R2 was not steady, but able to steady without human assistance while walking. During observation on 6/16/21, at 12:40 p.m. a large board, approximately 4 inches by 10 feet, was missing on the porch. There was no posted warning of the missing board. R5 came shuffling out of the building onto the porch, the surveyor alerted the administrator who had to hold R5's arm and guide him around the hole in the floor of the porch. R2 and R12 were sitting on the porch	F 689		

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F 689	Continued From page 17 and required staff to assist them around the missing board into the facility. NA-A had been sitting near the door and did not assist R5 out. NA-A stated she did not see this as a safety hazard, the residents could have spoken up if they needed assistance. The administrator stated maintenance was working on replacing the boards of the porch and should have notified staff and residents of this hazard. The policy or procedure on maintaining a safe environment for residents was requested but not provided.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate dementia care services to attain or maintain their mental and psychosocial well-being, for 1 of 1 resident (R2) when staff utilized inappropriate interventions to promote positive behavior with the resident. Findings include: R2's quarterly Minimum Data Set (MDS) dated 4/24/21, included moderate cognitive impairment, with a diagnoses including dementia, bipolar disorder and schizophrenia. R2 had signs of delirium including inattention and disorganization which fluctuated, and also had hallucinations and	F 744		

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delusions. R2 felt bad about herself and had thoughts of being better off dead. R2 was always incontinent of urine and had not attempted a toileting plan. She received antipsychotic and antidepressant medication daily.

R2's care plan dated 3/13/20, included R2 had impaired cognitive function due to dementia and directed staff to keep directions simple, present one step at a time to avoid confusion and to keep her routine consistent to decrease confusion. R2's care plan identified R2 was resistive with care and, "has denied the need for changing with, 'I am not wet, I am dry' r/t [related to] poor insight/motivation to toilet as needed." Staff were directed to: Reassure her that she can always come back for the activity and remind her of her goal to remain dry. Remind her that it is not appropriate to have soiled clothing. Praise for behavior that is appropriate. Remind to toilet before and after meals. R2's care plan also included, "Staff may provide incentives for [R2] to remain dry during outings or in the facility." However, the care plan did not include specifics of the incentives. The care plan also included R2 used psychotropic medications due to bipolar and schizoaffective disorder.

On 6/17/21, at 3:59 p.m. licensed practical nurse, (LPN)-C, reported R2 would give registered nurse (RN)-B money for a coffee from a specialty coffee shop. RN-B said R2 would wait for RN-B's car to come in and ask if she had her coffee, to which RN-B would respond, "does it look like I have coffee in my hand?" LPN-C reported RN-B verbally acknowledged she was entrusted with R2's money for coffee and would make using the funds for coffee contingent upon R2's behavior, R2 following her toileting program and R2 not

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irritating RN-B. LPN-C reported she witnessed these exchanges between RN-B and R2 on multiple occasions, as recent as May 2021. R2 would talk to LPN-C over the night time about how she had given RN-B money and she hoped she would get her coffee the next morning. LPN-C reported she did not think RN-B ultimately kept R2's money for her own gain, but felt staff should not take money and RN-B should not have waited an extended time period to get R2 her coffee with her own funds. LPN-C reported to her knowledge, it was not part of R2's care plan to have use of her own funds used to buy coffee, contingent upon her behavior. LPN-C reported she had reported her concerns to the director of nursing (DON). DON reportedly told LPN-C it was not a concern as the coffee eventually got purchased. LPN-C reported R2 was vulnerable from a mental and social standpoint as she wanted others to like her and did not want to get anyone in trouble and had previously been exploited by her peers. R2 was often distressed because the coffee would not come for days and worried she was not liked.

When interviewed on 6/15/21, at 12:15 p.m. R2 would not discuss her money being used by RN-B to buy her coffee contingent upon her behavior.

R2's resident's personal account ledger, dated November 2020 through June 17th 2021, was last updated on 6/1/21. The ledger indicated no accounting that RN-B had accepted money entrusted to her by R2 and no evidence RN-B had purchased coffee for R2 using R2's funds.

When interviewed on 6/17/21, at 3:19 p.m. registered nurse (RN)-B stated, R2 would give her money, five dollars, to buy coffee from a

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specialty coffee shop routinely. RN-B would take the money and get her the coffee continent upon R2's compliance with her toileting program. RN-B would keep the money up to a week before purchasing the coffee. RN-B stated they could give incentives to R2 to maintain her toileting program and this is what she did. RN-B stated it was not specifically part of R2's care plan or agreed upon by R2 as a behavior intervention.

An email from the director of nursing (DON), dated 6/17/21, indicated, "I will let you know that I know personally that [RN-B] provided the coffee for [R2]. [RN-B] and I used to ride together and we always work on the same days during the week and I can recall the day that [RN-B] said that she brought her Coffee. [RN-B] had told her that when she goes to get coffee that she would provide it to her but that she didn't know exactly when that would be. Therefore, when we were bringing coffee from home for ourselves we were not "buying" coffee for her. I have found that [R2's] claims were unsubstantiated because I know that she was provided with the coffee that she paid for, just not immediately."

A dementia care policy was requested, but not provided by the facility.

Electronically delivered

July 1, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 69GE11

Dear Administrator:

The above facility was surveyed on June 15, 2021 through June 18, 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
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
	00234	A. BUILDING: _____ B. WING _____	C 06/18/2021

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) 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 6/15/21, 6/16/21, 6/17/21, and 6/18/21, a licensing 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 and the following correction orders are issued. When corrections are completed, please sign and	2 000		

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2 000	Continued From page 1 date, make a copy of these orders email to: Karen.Aldinger@state.mn.us 651-201-3794 The following complaints were found to be SUBSTANTIATED: H5606013C (MN73799) H5606014C (MN73798) H5606015C (MN73796) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Upon receipt of an acceptable POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	2 000		
2 475	MN Rule 4658.0260 Subp. 3 Personal Fund Accounting and Records Subp. 3. Accounting system. A nursing home must establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing home on the resident's behalf. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure an appropriate accounting of resident funds was documented and funds used as directed by the resident in a timely fashion for 1 of 1 residents reviewed for facility	2 475		

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2 475	Continued From page 2 fiduciary responsibility of personal funds (R2). Findings include: R2's MDS, dated 4/24/21, revealed R2 had moderate cognitive impairment and hallucinations and delusions. R2 had a diagnosis of Schizoaffective disorder and dementia. On 6/17/21, at 3:59 p.m. licensed practical nurse, (LPN)-C, reported R2 would give RN-B money for a coffee from a specialty coffee shop. RN-B said R2 would wait for RN-B's car to come in and ask if she had her coffee, to which RN-B would respond, "does it look like I have coffee in my hand?" LPN-C reported RN-B verbally acknowledged she was entrusted with R2's money for coffee and would make using the funds for coffee contingent upon R2's behavior, R2 following her toileting program and R2 not irritating RN-B. LPN-C reported she witnessed these exchanges between RN-B and R2 on multiple occasions, as recent as May 2021. R2 would talk to LPN-C over the night time about how she had given RN-B money and she hoped she would get her coffee the next morning. LPN-C reported she did not think RN-B ultimately kept R2's money for her own gain but felt she staff should not take money and RN-B should not have waited an extended time period to get R2 her coffee with her own funds. LPN-C reported to her knowledge, it was not part of R2's care plan to have use of her own funds used to buy coffee, contingent upon her behavior. LPN-C reported she had reported her concerns to the director of nursing (DON). DON told LPN-C it was not a concern as the coffee eventually got purchased. LPN-C reported R2 was vulnerable from a mental and social standpoint as she wanted others to like her did not want to get anyone in trouble and had	2 475		

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2 475	Continued From page 3 previously been exploited by her peers. R2's care plan, intervention, dated 2/17/21, directed staff, "Staff may provide [R2] incentives to remain dry during outings or in the facility." The care plan did not direct staff to take money from R2 and then making her use of that money for the purchase of coffee dependent on compliance with her toileting program. R2's resident's personal account ledger, dated November 2020 through June 17th 2021, was last updated on 6/1/21. The ledger indicated no accounting that RN-B had accepted money entrusted to her by R2 and no evidence RN-B had purchased coffee for R2 using R2's funds. On 6/17/21, at 3:19 p.m., a registered nurse (RN)-B reported she previously held funds given to her by R2 for the purposes of purchasing a coffee from a specialty coffee shop. RN-B reported R2 would give her $5 on occasion. RN-B added that she would purchase R2's coffee for her, contingent upon compliance with toileting program. RN-B told R2 she would keep the money for a week before purchasing her coffee. RN-B reported there was no system to account for the money entrusted to her by R2. On 6/16/21 at 11:00 a.m. DON reported RN-B would take money from R2 to get her coffee. There was no system to document the exchange of money and goods between RN-B and R2. RN-B reported she was not concerned about residents entrusting staff with money to purchase goods for them. An email from DON, dated 6/17/21, indicated, "I will let you know that I know personally that [RN-B] provided the coffee for [R2]. [RN-B] and I	2 475		

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2 475	Continued From page 4 used to ride together and we always work on the same days during the week and I can recall the day that [RN-B] said that she brought her Coffee. [RN-B] had told her that when she goes to get coffee that she would provide it to her but that she didn't know exactly when that would be. Therefore when we were bringing coffee from home for ourselves we were not "buying" coffee for her. I have found that [R2's] claims were unsubstantiated because I know that she was provided with the coffee that she paid for, just not immediately. Staff will no longer be accepting money from residents directly unless it is for the pop machine outside of the building that they are not able to utilize themselves d/t mobility issues. Unfortunately we are just not going to be able to provide this service to them as we have in good faith in the past." The Resident Purchases Policy, dated June 2021, directed staff, " Policy: Staff (typically activity director [AD] or administrative assistant [AA], on occasion other staff may "pick something up") may assist resident with purchases, especially when the resident is unable to shop for themselves. Procedure:1. Resident or resident's guardian will inform staff of a need or want to purchase an item. AD shops at Walmart or Target once or twice a month. AD visits with residents to inquire if they would like to make a list of items to be purchased. 2. AD or AA will research the item(s) needed online or in a catalog and discuss with the resident 3. Once an item(s) is agreed upon by the resident or their guardian, the AD or AA will order online or go to a store to make the purchase. 4. AD or AA will keep the resident informed when to expect their purchase. Sometimes the resident may need gentle reminders that shipping is out of our control. 5. After the resident receives the purchase, if it is clothing and fits, staff will write with permanent	2 475		

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2 475	Continued From page 5 marker the resident initials on an interior label. 6. AD or AA will submit the receipt to the administrative office for reimbursement through the resident account by issue of a check. 7. In order to alleviate confusion, staff is not to take cash from a resident except if the resident wants a pop from the pop machine and is unable to ambulate outside to access the machine. 8. All purchases are to be reimbursed through the resident account checkbook upon presentation of a receipt." SUGGESTED METHOD OF CORRECTION: The administrator, book keeper or designee could develop a policy on recording and accounting for all resident funds entrusted to the facility as fiduciary. The administrator, book keeper or designee could train all staff and residents on the policy and audit periodically for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 475		
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.	2 830		

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess safety risk for 1 of 3 residents (R5) who were allowed to go into the community unsupervised, which placed R5 at risk for serious injury, impairment or death. R5 returned to the facility, which was located a block and half from a lake, wet from the chest down, had a head laceration which required emergency room care for staples, and was missing his shoes. In addition to the resident in immediate jeopardy, the facility failed to ensure the porch and deck area were free of potential accident hazards for 3 of 3 (R12, R5 and R2) who were on the deck area while decking boards were being removed which had the potential for harm that is not immediate jeopardy. The immediate jeopardy began on 5/9/21, when R5 attempted to climb over a gate on the 2nd floor of an outside deck, was unable to free himself from the gate, and the facility failed to assess R5 for safely leaving the facility independently. Subsequently on 6/9/21, R5 had returned from an unknown location to the facility wet from the chest down and with a head laceration. The immediate jeopardy was identified on 6/16/21. The director of nursing (DON) and administrator were notified of the immediate jeopardy (IJ) on 6/16/21, at 3:16 p.m. The immediate jeopardy was removed on 6/18/21, but noncompliance remained at the lower scope and severity level of a D- isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	2 830		

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2 830	Continued From page 7 Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/27/21, included severe cognitive impairment with diagnoses including dementia and Parkinson's disease. R5 had signs and symptoms of delirium including inattention and disorganized thinking that fluctuated, and also had hallucinations and delusions. R5 required supervision and oversight for transfers and ambulation and the assistance of one person. R5 had 2 or more falls since the prior assessment. R5's cognitive loss/dementia Care Area Assessment (CAA) dated 8/24/20, included, R5 required more assistance with cares, had difficulty completing tasks, and had impaired daily decision making skills such as choosing to wear inappropriate clothing for the weather. R5's falls CAA dated 8/24/20, identified risk for falling and had 3 falls from attempting to sit in a chair and did not safely judge how he could do so safely. R5's care plan dated 2/12/21, identified, "has impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia, impaired decision making, long term memory loss, short term memory loss." R5's care plan included interventions: "Cue, reorient and supervise as needed, remind [R5] to always let staff know where he is going when he goes for a walk, make sure he is dressed appropriately and is appropriate at the time for independence outside of the facility." A written note dated 5/9/21, indicated R5 attempted to leave without notice via the upper deck and sustained an injury and the new intervention indicated, "new door alarm installed on upstairs emergency exit." R5's care plan further detailed R5 as having a court appointed guardian as R5 was unable to make	2 830		

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2 830	Continued From page 8 safe decisions for himself. R5's care plan also identified the risk for falls detailing, "R5 is high risk for falls r/t confusion, gait/balance problems, medications, lack of safety awareness and Parkinson's Disease," with hand written notation dated 5/9/21: "needs ^ [increased] supervised 30 min checks, " and "[R5] will be supervised by staff." Followed by note dated 5/19/21, "Staff will assist him when sitting in a chair in dayroom." R5's progress note dated 5/9/21, at 11:43 a.m. indicated the facility received a phone call from a neighbor, "someone was stuck on the steps." R5 was found straddling a gait from the back upper deck of the facility. R5 reported he had been there for 2 hours, he had blood running down his leg and reported to staff that he had been bitten, "by weasels." Facility staff assisted R5 into the home but he was too weak and shaking to assist to the main level of home. Staff left R5 seated on the bed while she went to get supplies to assist to clean area on leg and when she returned R5 was on the floor bleeding from his head. R5 was sent to the hospital via ambulance. R5's facility fall/incident report dated 5/9/21, at 5:30 a.m. described R5's incident, "fall and attempt to leave," location of incident noted, "bedroom and upper deck." Nursing notes section further detailed, "resident was discovered on upper deck attempting to climb over gate. He had small laceration on his leg and toe. Returned to his bedroom he then fell and hit his face, lacerations above left eye sustained - 911 called and he was sent in." The report detailed R5 has a history of falls and impaired safety awareness/judgement, as well as dementia and Parkinson's disease. R5's Fall Risk Assessment dated 5/9/21,	2 830		

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2 830	Continued From page 9 identified R5 was at high risk for falls and had 3 or more falls in the past 3 months, had intermittent confusion, vision was poor, and had a balance problem while ambulating, Even though R5 was at high risk for falls, he had not been assessed for safety while going for walks in the community independently. R5's progress note dated 5/16/21, indicated his gait was, "off," and was leaning to the side. R5's Fall Risk Assessment dated 5/19/21 identified R5 was at high risk for falling due to confusion, poor vision, balance problem while standing and ambulating, medication use and predisposing conditions. Even though R5 was at high risk for falls, he had not been assessed for safety in going for walks in the community independently. R5's progress note dated 5/20/21, identified he required extensive assistance with transfer and ambulation and was leaning to the left. However, he had not been assessed for safety in going into the community without supervision and his care plan had not been updated. R5's late entry progress note dated 6/7/21, at 6:32 p.m. indicated R5 returned from a walk in wet clothing from the chest down, missing his shoes and bleeding from a laceration on his head. R5 was unable to recall where he was or what happened. R5 was sent to the hospital via ambulance. R5's facility fall/incident report dated 6/7/21, at unknown evening time, described R5's incident as a, "mechanical fall" location outside. "Res [resident] presents with a laceration to R [right] forehead, small abrasion to L [left] back and no	2 830		

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2 830	Continued From page 10 shoes on. Res unable to state where his shoes are or how he fell, agreeable to every suggestion. Laceration continues to ooze blood so he was sent via ambulance to Methodist for evaluation. Residents clothing was also wet and he could not explain why." Lake Minnetonka, a large body of water, was located within a block and a half of the facility. 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. The facilities nurse communication log book, dated 6/14/21, directed staff: "[R5] is no longer allowed to go outside for walks without staff supervision." R5 did not have an assessment and his care plan had not been updated. When interviewed on 6/15/21, at 1:05 p.m. nursing assistant (NA)-C stated R5 is able to go for walks without supervision as long as he is properly dressed for the weather. NA-C stated she was aware of R5's recent falls and the incidents on 5/9/21 and 6/7/21, however, there were no new interventions and R5 was still able to go for walks unsupervised. On 6/15/21, at 3:13 p.m. NA-B stated R5 was allowed to go out on walks by himself, he was unsteady and had memory problems, but was not aware of any new guidance for him. Staff typically checked on R5 at beginning of shift, at meal times and when offering him assistance with toileting every couple of hours. There was an alarm on the doors and staff tried to see who went out when it would alarm.	2 830		

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(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
2 830	Continued From page 11 On 6/15/21 at 3:33 p.m. registered nurse (RN)-A, stated R5 was resistant to redirection for cares, would wear clothing inappropriate for the weather, walked with a shuffling gait and had a propensity for falls. R5's cognitive ability was variable, and would ask nonsensical questions and was unable to make decisions for himself. However, R5 was allowed to sign out and leave the building on his own. R5 liked to walk down the road watch the construction workers, he may sit in a swing in the yard. RN-A stated one time R5 was lost in the community and someone brought him back. If there were any concerns for R5's location, the local police department would likely find him and bring him back, as the local police were familiar with the facility residents. R5 had previously worn a GPS unit, but that had been discontinued because R5 would remove it. RN-A had never completed an elopement or safety assessment for R5. RN-A was not aware of any new interventions for R5. On 6/15/21, at 4:15 p.m. the activity director (AD) reported R5 would previously swing in the yard and walked to watch the construction workers at a nearby site in the neighborhood on his own, without staff supervision. AD reported R5 had problems a couple times recently and was now not able to go out on his own. AD explained the door bell would go off when staff, residents or visitors entered or exited the building. When it rang, staff were supposed to check and see who was entering or exiting and redirect if the resident was not safe to go outside on his own. AD explained R5 did not have shoes. AD described she was working in the kitchen one evening when R5 returned from the community and was wet, had no shoes on and had a cut on his forehead. AD explained R5 was supposed to sign out, but	2 830		

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	00234	A. BUILDING: _____ B. WING _____	C 06/18/2021

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2 830	Continued From page 12 had noted R5 had not signed out that day. AD explained R5's pants were wet and thought R5 might have walked to a nearby public beach, approximately one block away, took his shoes off and walked in the sand. R5 was not able to articulate where he had gone. R5 had returned wearing a pair of jogging pants and a t-shirt. R5 was gone for about an hour. AD reported the DON told her that night that R5 could no longer go outside on his own. AD reported R5 took direction well, but was "hard headed" at times, was sometimes forgetful of where he placed belongings and would get anxious and would require staff redirection as he wore multiple coats while it was hot outside and winter boots while walking up and down the stairs at the facility. When interviewed on 6/15/21, at 1:33 p.m. licensed practical nurse (LPN)-A stated "I would not let him out on my shift unless he goes with staff, his cognition is hit or miss, along with his medications that have changed, his speech pattern difficult to understand him," and indicated overall R5 was not safe out in the community without supervision. LPN-A stated R5 used to have a GPS tracking device, but it was on hold and did not know why. R5 was supposed to sign out when he would leave for a walk, but often forgot due to his dementia. The Lake Minnetonka Care Center May/June 2021, Release of Responsibility for Leave of Absence sign out form failed to identify R5 had signed out to go for a walk at all on 6/7/21. When interviewed on 6/16/21, at 8:27 a.m. Director of Nursing (DON) stated, on 6/7/21, R5 had still been allowed to go out for walks unsupervised, she did not feel he was an elopement risk as he had always come back to	2 830		

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2 830	Continued From page 13 the facility, even though he has severe cognitive impairment, delusions and Parkinson's disease and had fallen many times. The DON stated in the past, community members had brought R5 back to the facility and if he fell while out on a walk, a community member would help or the police would. R5 used to wear a GPS watch, but it was stopped as R5 would normally just stay on the road the facility was located on. R5 was supposed to sign out each time he went for a walk, however, often would forget and did not sign out on 6/7/21. On 6/7/21, they did not know how long he had been gone, or where he had walked to, R5 returned to the facility with a head injury, had dirt and leaves in his beard and was wet. R5 stated he had fallen into rocks while walking up a hill. The DON stated they gave R5 a shower as they did not know why he was wet, but assumed it could have been from a sprinkler system in the community. When interviewed on 6/16/21, at 10:49 a.m. Psychiatric Nurse Practitioner (NP)-E stated, R5 should not go for walks in the neighborhood alone due to his balance issues, psychosis and dementia. When interviewed on 6/17/21, at 9:10 p.m. R5's primary physician (PCP) stated the situation of R5 walking around the neighborhood unsupervised did not come up during his visits with R5, but was aware R5 had recent falls. PCP stated with R5's most recent falls he had concerns related to the disease process of R5's Parkinson effecting his mobility, as well as R5's overall cognitive functioning. PCP further added after the 6/7/21 fall that R5 "not be advised to go out in community without supervision again." During observation on 6/16/21, at 12:30 p.m. with	2 830		

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2 830	Continued From page 14 the administrator the following was observed: On the second floor there was a door open to a small deck leading to a set of several stairs. At the top of the stairs there was a worn and weathered wooden gate that was the width of the stairs and about 3 feet in length, that reached to approximately 4 feet off the ground. There were sticks and leaves on the deck. This had been the deck and gait R5 had been trapped in on 5/9/21. The administrator stated the gait had not been assessed for safety before or after R5's incident. When interviewed on 6/16/21, at 2:52 p.m. R5's legal guardian (LG) stated he was unaware if R5 was allowed to walk around in the neighborhood without staff supervision and had assumed staff were present, but was aware R5 walked the grounds of the facility. Guardian stated, "I would not favor R5 walking around in the community." A facility policy titled, Elopement/Wandering Policy, dated 05/2020, included: Lake Minnetonka Care Center (LMCC) will assess for elopement/wandering concerns upon admission to our facility. Proper training will be given to all employees regarding the monitoring and handling of such residents who may be at risk. Procedure: 1. LMCC's Director of Nursing will assess residents for elopement/wandering. concerns upon admission to our facility. Quarterly assessments will be completed thereafter. For residents that have been identified at high risk, monthly assessments will be completed. All staff will be made aware of at risk residents. 2. Resident care plans will list interventions being used for wandering/elopement. 3. Staff are to document wandering in Target Behavior book.	2 830		

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2 830	Continued From page 15 5. Proper training will be given to all employees regarding the monitoring and handling of residents who may be at risk. 6. Training will include but not be limited to routine room checks, door alarm procedures, GPS watch monitoring (if applicable), and general resident demeanor (signs/triggers for possible elopement escalation). 9. In the event a resident appears to have eloped, all staff on duty will be alerted and will assist with immediately checking the facility and grounds along with the local neighborhood. If unable to locate resident, Charge Nurse will contact the local police and report a missing person. 10. The Charge Nurse will then contact the Administrator and Director of Nursing. 11. Either the Administrator or Director of Nursing will file a Vulnerable Adult report online. 14. Upon location of the resident, an assessment will be completed as to the physical, emotional and mental well-being of the resident to determine if hospitalization is required. 15. Staff will discuss the situation to evaluate what happened and how this could be avoided/handled if a future situation were to occur. 16. Reports will be completed and all parties notified. 17. Close monitoring of the residents' whereabouts and demeanor will be a priority. The immediate jeopardy which began on 5/9/21, was removed on 6/18/21, at 12:13 p.m. when it was verified through record review the facility had completed a Wandering Risk Assessment and Wandering Risk Scale for R5, R5's care plan was updated to include R5's legal guardian or staff were now required to accompany him to all appointments and outings. An Angel Sense monitor, which is a GPS tracking device had been	2 830		

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2 830	Continued From page 16 ordered and verified by FedEx to arrive on 6/18/21. Until then, staff were to be alert for R5 exiting the facility via the door alarms, this was verified by documentation of education and staff interviews with RN-B, LPN-B, NA-A, NA-C and NA-D. R5 was to have 30 minute checks which were being signed out by staff as completed. The facility had also completed Wandering Risk Assessments on all facility residents. It was determined 10 residents (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11) were unsafe to leave the facility independently, other than the deck. The list of residents was placed in the office nursing staff use, in the kitchen and utility room. Each residents care plan was updated to reflect this. Education sign in sheets indicated all staff working had been educated on the elopement policy, residents who were unsafe to leave the facility independently, training on the door alarms and 30 minute checks was provided. Staff had been alerted they were required to attend this training prior to starting their next shift. This was verified by staff interview on 6/18/21, between 9:00 a.m. and 12:00 p.m. However, noncompliance remained at the lower scope and severity level of a D- isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy, because R5's sensor had not arrived yet and continued education was required. R12's MDS dated 3/23/21, included, cognitively intact and had impaired vision. R12 required supervision with walking in corridor and was not steady, but able to steady without human assistance while walking. R2's MDS dated 4/24/21, included, moderate	2 830		

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2 830	Continued From page 17 cognitive impairment, required extensive assistance of one person for walking in corridor. R2 was not steady, but able to steady without human assistance while walking. During observation on 6/16/21, at 12:40 p.m. a large board, approximately 4 inches by 10 feet, was missing on the porch. There was no posted warning of the missing board. R5 came shuffling out of the building onto the porch, the surveyor alerted the administrator who had to hold R5's arm and guide him around the hole in the floor of the porch. R2 and R12 were sitting on the porch and required staff to assist them around the missing board into the facility. NA-A had been sitting near the door and did not assist R5 out. NA-A stated she did not see this as a safety hazard, the residents could have spoken up if they needed assistance. The administrator stated maintenance was working on replacing the boards of the porch and should have notified staff and residents of this hazard. The policy or procedure on maintaining a safe environment for residents was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to elopement and accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating 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.	2 830		

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2 830	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		