Electronically delivered
August 4, 2021

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

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

Dear Administrator:

On july 1, 2021, we informed you of imposed enforcement remedies.

On July 15, 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. 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 July 15, 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/revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 15, 2021, will remain in effect.

This Department continues to recommend that CMS impose a 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 15, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 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.

As we notified you in our letter of June 23, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 18, 2021.

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:

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 07/15/2021

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F 000	INITIAL COMMENTS On 7/12/21, through 7/15/21, 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 complaint was found to be SUBSTANTIATED: H5606016C (MN0074385) with deficiencies issued at F689, F712, F580, F609, and F758. The survey resulted in an Immediate Jeopardy (IJ) at F689 when R1 successfully eloped from the facility, through two alarmed doors and went off the facility ground. The facility did not know R1 had been missing. The IJ began on 6/30/21, and the immediacy was removed on 7/15/21. The above findings constituted substandard quality of care, and an extended survey was conducted from 7/14/21, to 7/15/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Please email your POC to: Susan.frericks@state.mn.us 218.368.4467 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.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify a resident's representatives (family and case manager) when a resident had an elopement from the facility for 1 of 3 residents (R1) who were reviewed for notification of changes. Findings include: R1's Face Sheet dated 7/13/21, indicated diagnoses of dementia, depression, schizoaffective disorder and anxiety disorder. The Face Sheet also indicated family member (FM)-G and case manager (CM)-H were R1's contacts. R1's annual Minimum Data Set (MDS) dated 5/23/21, indicated severe cognitive impairment. R1 walked in his room and in the corridor independently. R1 did not require a device for mobility. The MDS indicated R1's family or guardian did not participate in R1's MDS assessment. R1's Physician Orders dated 7/13/21, indicated to complete a wander risk scale monthly and to wear a Keruve GPS Watch.	F 580		

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F 580	Continued From page 3	F 580		

R1's care plan dated 8/30/19, indicated R1 enjoyed health walks and should be encouraged to take his health walks on the deck and/or walk with staff. Staff were to encourage R1 was a high elopement risk and wanderer due to his impaired safety awareness and dementia; R1's last elopement was on 6/30/21.

R1's Falls/Incident Report dated 6/30/21, indicated R1 eloped from the facility because he wanted to go on a "health walk." The Falls/Incident report indicated staff noted R1 was missing and conducted a whole house search. The Keruve GPS watch indicated R1 was within the two block radius of the facility therefore staff went to go find him. R1 was redirected back to the facility. The incident report indicated the R1's doctor was notified when R1 elopement. There was no indication R1's guardian or family/friend were notified.

R1's initial Activity Evaluation dated 5/21/19, indicated R1's family members (FM)-G and FM-I were very involved and R1 felt grateful.

During an interview on 7/13/21, at 11:27 a.m. FM-G stated he had not been notified that R1 had had an elopement since last year. FM-G stated R1's memory was bad and he was concerned as R1 did not know his way around.

During an interview on 7/13/21, at 12:54 p.m. R1's case manager (CM)-H stated she had not been notified if R1 had an elopment.CM-H stated she would want to know if R1 was lost in the community and if R1 was noted to not be safe.

During an interview on 7/15/21, at 10:14 p.m. R1 stated he would like FM-G and FM-I to know if

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F 580	Continued From page 4 something happened to him. During an interview on 7/13/21, at 2:59 p.m. the director of nursing (DON) stated R1 had severe cognitive impairment and poor judgement. The DON stated R1 represented himsef and had they not done anything to find R1 a representative. The DON verifeid she did not contact R1's case manager or family after R1's elopement. The DON further stated R1 was his own decision maker but would ask R1 if it was ok to contact FM-G and FM-I if there was an incident. The DON verified she did not ask R1 if she could contact FM-G and FM-I about his elopement which she should have due to his cognition. Also, the DON stated she maybe should have contacted CM after R1's elopement as well. A policy on notification of changes was requested but not provided.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		

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F 610	Continued From page 5 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 thoroughly investigate an injury of unknown origin for 1 of 3 residents (R1) who were reviewed for elopement. Findings include: R1's Face Sheet dated 7/13/21, indicated diagnoses of dementia, depression, schizoaffective disorder, thoracic aortic ectasia (aortic vessel dilation), hypertension (HTN) and anxiety disorder. R1's annual Minimum Data Set (MDS) dated 5/23/21, indicated severe cognitive impairment. The MDS also indicated R1 was not at risk to develop pressure ulcers and did not have a pressure ulcer wound or skin problem. R1's care plan dated 8/20/19, indicated R1 was at high risk for falls and was on anticoagulant medication. R1's progress note dated 4/15/521, at 7:06 a.m. indicated a large bruise was found on R1's right forearm which was purplish-red with some yellow around the edge. R1's progress note dated 4/15/21, at 12:28 p.m. indicated R1 had a large bruise on the outside of his right forearm which was dark purple in color with yellow around the edges. The worst of the bruise measured 11 centimeters (cm) by 6.5 cm. This bruise extended down to R1's hand which	F 610		

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F 610	Continued From page 6	F 610		

measured 5 cm x 6 cm which was light purple and green in color. In the middle of the bruise on R1's forearm there was a scab the size of a pen-tip with a lump, or hematoma underneath it. R1 stated he had no pain and did not have a recollection on how the bruise appeared.

During an interview on 7/13/21, at 3:09 p.m. the director of nursing (DON) asked registered nurse (RN)-A if she knew how R1 obtained the bruise on 4/15/21. RN-A stated R1 may have had labs drawn which caused the bruise. The DON responded to RN-A and said, "didn't he go in for chest pain" and R1's lab draw was 10 days prior to the onset of the bruise. The DON and RN-A verified they were unable to determine how R1 obtained the large bruise on his forearm.

During an interview on 7/13/21, at 3:17 p.m. the DON verified there should have been a skin assessment and change in condition assessment after the bruise was found on R1's forearm on 4/15/21 to determine the cause. The DON verified she did not have an investigation report as they did not investigate the investigate the cause of the bruise

A facility policy on an injury of unknown origin was requested but not provided.

The facility policy Skin Assessments dated 7/2021, indicated an assessment should be completed under "Assessments" in the residents chart anytime a resident has a bruise.

The facility Vulnerable Adults Policy and Procedure Plan dated 2/20, indicated the facility had a vulnerable adult protection plan. This plan was a system established for investigation of

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F 610	Continued From page 7 possible incidents or allegation which need investigation.	F 610		
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 interview and document review, the facility failed to prevent an elopement and provide safety for 1 of 3 residents (R1) identified at risk for elopement who successfully eloped from the building, undetected, and was found a block and a half away approximately twenty minutes later. This deficient practice resulted in immediate jeopardy for R1. The elopement immediate jeopardy (IJ) began on 6/30/21, when R1 successfully eloped from the facility, through two alarmed doors and went off the facility grounds. The facility did not know R1 had left. On 7/13/21, at 4:14 p.m. the director of nursing (DON) was notified of the IJ for R1. The DON was notified that the immediate jeopardy was removed on 7/15/21, at 12:30 p.m. but noncompliance remained at a lower scope and severity level of D- isolated scope and severity level which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689		

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F 689	Continued From page 8 Findings include: R1's Face Sheet dated 7/13/21, indicated diagnoses of dementia, schizoaffective disorder, hypertension (HTN) and anxiety disorder. R1's annual Minimum Data Set (MDS) dated 5/23/21, indicated severe cognitive impairment. R1 walked independently in his room and in the corridor. The MDS indicated R1 wandered one to three times out of seven days. R1's Physician Orders dated 7/13/21, indicated to complete a wander risk scale monthly and to wear a Keruve GPS Watch (GPS wristwatch which has a portable receiver; when the "locate" button on the receiver is pushed, the precise position of the person who wears the watch was shown on the screen's map.). R1's care plan dated 5/26/21, indicated R1 enjoyed health walks and should be encouraged to take his health walks on the deck and/or walk with staff. Staff were to encourage R1 to use an inhaler prior to exercise. R1 was a high elopement risk and wanderer due to his impaired safety awareness and dementia; R1's last elopement was on 6/30/21. There were no additional interventions indicated to keep R1 safe after his elopement on 6/30/21. R1's Wander Risk Assessment dated 6/16/21, indicated R1 exhibited/expressed fear and/or anxiety. R1 was disoriented and was forgetful/short attention span. R1 was independent with mobility and was a known wanderer and had a history of wandering. R1's Wandering Risk Scale dated 6/16/21,	F 689		

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indicated R1 was at high risk to wander; had a history to wander and had wandered in the past month. R1 had a history of elopement and wore a Keruve GPS watch for safety on those occasions when staff did not see R1 leave. R1 was not safe to go out in the community independently as he would not remember where he lived.

R1's Falls/Incident Report dated 6/30/21, indicated R1 had an incident of an elopement 9:00 a.m. The Falls/Incident Report indicated staff noticed R1 was missing, conducted a whole house search, and then used the Keruve GPS watch to locate R1. The Keruve GPS watch indicated R1 was within the two-block radius of the facility; therefore, staff went to find him. R1 was redirected back to the facility. The report indicated the cause of the incident was because R1 wanted to go on a "health walk".

The Nursing Home Incident Report dated 7/2/21, indicated R1 left the building while staff were distracted in another resident room. According to another resident, R1 walked to the end of the block and back twice; then he went around the block. The Keruve GPS watch alarm did not sound because R1 did not leave the 1 1/2 block radius set on the Keruve GPS watch system. The system depends on satellite to locate the GPS device that R1 wore.

The facility's Nursing Safety Checklist Log dated 6/21, lacked indication R1's Keruve GPS watch safety check had been completed on the morning of 6/30/21. Also, the Nursing Safety Checklist Log lacked indication the front and back doors alarms were checked on 6/30/21.

R1's Wandering Risk Scale dated 7/4/21,

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F 689	Continued From page 10 indicated R1 was a high risk to wander and had wandered the past month. R1's progress notes indicated previous wandering and elopement attempts, and unsafe behaviors occurred on: -1/23/21, R1 attempted to leave the facility through the back door. -1/31/21, R1 was missing from at least 1:30 p.m. until 2:20 p.m. R1 was wheezing upon arrival back at the facility. A new intervention was to keep R1's winter coat behind the nurses station. -2/8/21, the back vestibule door was open when R1 walked down the hall for his "health walks." -3/3/21, R1 reported he had been trying to remove his Keruve GPS watch for the past two days. -3/17/21, R1 went out the back of the facility for a health walk. R1 wore his Keruve GPS watch but had not left the two block radius for it to sound. -4/13/21, registered nurse (RN)-A was in another resident's room when she was informed by a nursing assistant (NA) that R1 had walked outside and down the block. RN-A went outside and met R1 on the corner of another block. R1 was in jeans, a sweatshirt and hat; it had been snowing a few minutes before and the temperature was below 40 degrees Fahrenheit (F). R1 did not realize it had been that cold and told RN-A he had a list of things to get from the store. When R1 arrived back to the facility he experienced shortness of breath (SOB) and his breathing went back to normal after a few minutes. -4/14/21, R1's Keruve GPS watch appeared to have been tampered with during an attempt to remove it as the band had light scratches on it with markings of ink pen that was used to release the mechanism.	F 689		

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F 689	Continued From page 11 -4/16/21, R1 opened the back door three times within 10 minutes. R1 was also seen in the day room "fidgeting" with the front door handle. R1 wanted to see what the weather was outside, but staff directed R1 to the deck. R1 agreed to go to the deck but kept circling back and opening the back door. -4/23/21, R1 left the facility but staff found R1 outside, on the facility grounds. R1 stated he went for a health walk. -5/17/21, R1 did not know the name of the facility nor what day or year it was. -5/23/21, R1 ambulated independently and liked to walk. R1 appeared to be bored at times and would pace the hallway which R1 called a "health walk." -5/28/21, one out of two of R1's Keruve GPS watches did not function correctly which could not track his location. -6/10/21, R1 had two Keruve GPS watches. One watch was not charged, and the other watch did not work correctly as it could not locate R1. -6/30/21, R1 was noted to not be in the facility at 9:20 a.m. after a whole house search. The Keruve GPS watch indicated R1 was still within two blocks of the facility therefore staff went to find him. R1 was found about 1.5 blocks from the facility and brought back to the facility. R1 was reminded he shouldn't leave the facility since he could not find his way back. R1 stated he understood; sometimes when he took a walk he could not find his way back. The progress note also indicated R10 reported she had seen R1 walk back and forth on the road in front of the facility a few times and then turned down another street. The progress note indicated no other interventions were needed. -7/9/21, R1 tried to elope out the back door but a housekeeper steered R1 back into the facility.	F 689		

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F 689	Continued From page 12 -7/12/21, indicated R1 did not have his Keruve GPS watch on as it needed to be charged. During an observation and interview on 7/12/21, at 1:48 p.m. the back alarmed door was visually wide open to the outside. The DON stated the back door "got stuck" if it was left open. The back door alarm would not sound if te door was left open. The back door, was one of two alarmed doors which R1 went out the day he left the building unattended on 6/30/21 and staff was not aware it sounded. During an observation on 7/12/21, at 3:15 p.m. R1 was in the dining room by an alarmed door and did not have his Keruve GPS watch on. During an interview on 7/12/21, at 8:40 a.m. DON stated R1 wore a Keruve GPS watch which alerted staff if R1 went farther than a two-block radius of the facility. The DON also stated the facility could look up on a tablet where R1 was located within the two-block radius but could not look where R1 was if he went beyond the two-block radius. The DON further stated the Keruve GPS watch did not work correctly or consistenly if there were weather conditions outside. During an interview on 7/12/21, at 9:00 a.m. R1 stated he liked to go on a health walk every day for a half hour and planned to go for a walk later that day. R1 stated he took health walks around the facility but preferred to take a walk outside to get a "good sweat." R1 stated he had a certain route he took around the block by himself if he did not walk to a store. R1 also stated he had gotten lost before when he was alone and had struggled to figure out how to get home. R1 stated he would	F 689		

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get lost when he "overthought" things and possibly turned on the wrong road. R1 further stated it was his routine of 30 years to take a health walk and he liked to go early in the morning or first thing after lunch.

During an interview on 7/12/21, at 9:12 a.m. nursing assistant (NA)-B stated R1 tried to go on walks alone outside but needed staff to go with him. NA-B also stated when R1 tried to leave the alarm doors should sound but if it does not, he had a Keruve GPS watch where staff can look up on the tablet where R1 was if he was within a two block of the facility.

During an interview on 7/12/21, at 10:17 a.m. RN-A stated there were four alarmed doors in the building. RN-A stated there were two alarms on the back doors, one alarm on the door by the day room and an alarm on the upstairs balcony. RN-A further stated she would not be able to hear the door alarms go off if she was on the second floor doing cares.

During an interview on 7/12/21, at 12:03 p.m. NA-A stated she worked on 6/30/21, the day R1 successfully left the facility. NA-A stated she realized R1 left when she went to his room to get him for his shower and realized he was not there. NA-A stated she told the DON after she could not find R1 when she looked throughout the facility. The DON looked on a tablet which helped track the location of R1. NA-A stated she got into her car and found R1 down the street, approximately 1.5 blocks away. NA-A stated it scared her that R1 got into the car with her since R1 did not really know who she was as NA-A did not work often. NA-A further stated R1 had "bad dementia" and R1 went with her even though he didn't know who

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she was; anyone could have picked him up. NA-A stated after this incident she was not aware of any new interventions that were put into place as they already had the door alarms and Keruve GPS watch that would alert staff if he went past two blocks of the facility. NA-A further stated she did not hear the door alarm sound when R1 left the facility on 6/30/21. NA-A stated she guessed it was likely related to the two back alarmed doors were left open therefore the alarms did not sound.

During an interview on 7/12/21, at 12:23 p.m. activities director (AD)-A stated R1 walked out the back door often and was "sneaky". AD-A stated when she worked in the evening R1 tried to leave two or three times during a shift and she had to redirect him back. AD-A stated if R1 left the building he could get hurt within the two-block radius by falling. AD-A also stated she did not take R1 for health walks and R1 did his health walks within the building.

During an interview on 7/12/21, at 1:18 p.m. RN-A stated if R1 left the facility he would not know how to get back to the facility. RN-A stated it was hard to respond to the door alarms with all the people going in and out. RN-A stated R1 ate during the first meal round and liked to walk up and down the hallways after he ate. RN-A stated she would redirect R1 back to his room since RN-A was busy assisting other residents for the second meal shift. RN-A further stated R1 has left before and snuck out the back door. RN-A stated on 4/13/21, R1 successfully left after lunch when she was busy giving another resident medication, the NA was in the day room, and they did not hear the door alarm go off when R1 left. RN-A further stated on 4/13/21, she looked for R1 once she realized he was gone and found him walking

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down the block. RN-A further stated R1 also left out the back door on 3/17/21, but staff were able to intervene before he left the facility grounds. RN-A stated she knew it was a trigger for R1 to want to go on a walk after meals, but they just redirected him back to his room. RN-A stated on 5/18/20, R1 was found after lunch time by police sleeping under a park bench and had garbage all around him. RN-A further stated staff were busy, and they could not keep an eye on R1 "24 hours a day seven days a week" therefore he wore a Keruve GPS watch to find him when he left the building.

During an interview on 7/14/21, at 12:26 p.m. R10 who had intact cognition (brief interview of mental status (BIMS) was 15 for 4/2/521 quarterly MDS) stated she saw R1 walk outside her window on 6/30/21, around 9 a.m., after breakfast. R10 also stated the DON was on a video chat with someone when she tried to inform the DON that she saw R1 outside. R10 stated she was not sure if she heard the door alarm go off or not when R1 left on 6/30/21.

During an interview on 7/12/21, at 2:05 p.m. the DON stated NA-A searched the facility but could not find R1. The DON pushed locate on the tablet and found R1 down the road. The DON further stated after R1 was found there were no additional interventions put in place since they followed R1's care plan and could find him with the Keruve GPS watch. The DON stated if R1 left the two-block radius she would get notified by an alarm but R1 was within the two-block radius therefore his Keruve GPS watch did not notify the DON. The DON stated she did not think anything bad would happen, or anyone would harm R1 within the two-block radius of the facility since it

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was a "good neighborhood." The DON additionally stated the Keruve GPS watch would not work if there was bad weather or if it was too cloudy. The DON stated R1 has tried to remove his watch in the past. The DON stated she could not provide the exact length of time R1 was gone on 6/30/21, but thought it was for approximately 20 minutes.

The facility Elopement/Wandering Policy dated 7/21, indicated a patient who leaves the facility without notice in a nursing home setting was known as elopement.

The IJ was removed on 7/15/21, at 12:30 p.m. after it was verified through observation, interview, and record review the facility provided interventions to prevent R1 from eloping from the facility.
- at 9:59 an observation of the facility door alarms on all the exit doors were set to the highest sound level. An observation was also made of three new security cameras which were installed outside of each exit that would send an audible alert to a device which the nurse on duty would always have.
-at10:02 a.m. RN-A showed the new device and how it functioned.
-at 10:08 a.m. the DON explained the process on how staff would offer to accompany R1 to go for a walk or offer to "walk within view" in the neighborhood to provide R1 the ability to complete his exercise routines.
-at approximately 10:15 a.m. until 11:44 p.m. an observation that R1's location was monitored every 15 minutes during waking hours to make sure they knew where R1 was at within in the building.
-at 11:44 a.m. RN-A and housekeeper were

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F 689	Continued From page 17 observed to receive education to ensure doors were completely shut to ensure the door alarms go off and the interventions put into place to keep R1 safe. Additionally, the facility elopement policy was updated to reflect the addition of the outdoor motion cameras and staff were educated on the new systems in place.	F 689		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were seen every 30 days for the first 90 days and every 60 days there after for 2 of 3 residents (R2, R3) reviewed for physician visits.	F 712		

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Findings include:

R2
R2's Face Sheet dated 7/13/21, indicated diagnoses of schizoaffective disorder, diabetes mellitus (DM) type 2, asthma, hyperlipidemia, Hypertension (HTN), chronic obstructive pulmonary disease (COPD), and chronic kidney disease (CKD) stage three. R1 admitted on 1/12/11.

R2's After Visit Summery dated 1/3/20, indicated R2 was seen by her provider.

Documentation of a provider visit between 1/3/20, until 6/12/20, was requested but was not provided.

R2's After Visit Summery dated 6/12/20, indicated R2 was seen by her provider.

R2's After Visit Summery dated 1/15/21, indicated R2 was seen by her provider.

R2's After Visit Summary dated 4/2/21, indicated R2 was seen by her provider.

During an interview on 7/14/21, at 12:46 p.m. the director of nursing (DON) stated there had been no provider visit for R2 between 1/15/21, and 4/2/21. The administrative assistant (AA) and DON verified it had been 77 days from when R2 was seen on 1/15/21, until 4/2/21. The DON verified R2 should have been seen within 60 days.

During an interview on 7/14/21, at approximately 12:49 p.m. the DON stated she was not able to

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F 712	Continued From page 19 find a provider visit between 1/3/20, and 6/12/20. The DON stated she would provide one if one was found. The DON verified R2 should have been seen within 60 days. The DON did not provide documentation of a provider visit for R2 from 1/3/20, until 6/12/20. R2 was not seen by a provider for 161 days. R3 R3's Face Sheet dated 7/14/21, indicated diagnoses of insomnia, constipation, depression, anxiety, obsessive compulsive disorder (OCD), and schizoaffective disorder. The Face Sheet also indicated R3 admitted on 12/9/19. R3's Provider Progress note dated 12/16/19, indicated R3 was seen by his provider. R3's Provider Progress note dated 1/14/20, indicated R3 was seen by his provider. R3's Provider Progress note dated 3/23/20, indicated R3 was seen by his provider. R3's Provider Progress note dated 5/15/20, indicated R3 was seen by his provider. R3's Provider Progress note dated 8/11/20, indicated R3 was seen by his provider. During an interview on 7/14/21, at 12:52 p.m. the administrative assistant asked the DON if R3 was seen by the provider in 2/2020. The DON told the AA that he was seen by psychiatry but not his provider. The AA stated it had been 69 days from when R3 was seen on 1/14/20, until 3/23/20. The DON verified R3 should have been seen every 30 days for the first 90 days. The DON also verified the their facility Physician Visit policy needed to	F 712		

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F 712	Continued From page 20 be updated to reflect this. During an interview on 7/14/21, at approximately 12:55 p.m. The administrative assistant and DON stated R3 should have been seen every 60 days. The AA and DON verified that it had been greater than 60 days from R3's physician visit on 5/15/20, until 8/11/20. R3 was not seen by a provider for 88 days between 5/15/20, and 8/11/20. The facility Physician Visits policy dated 10/1995, indicated residents would receive ongoing 60 day check ups after their admission examination.	F 712		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		

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F 758	Continued From page 21 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side effect monitoring was completed for prescribed psychotropic medication for 4 of 4 residents (R2, R3, R4, R5) reviewed for unnecessary medication use. Findings include: R2 R2's annual MDS dated 1/22/21, indicated R2 required supervision for transfers, bed mobility, walking in rooms, eating, and locomotion. R2's	F 758		

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MDS further indicated R2 required limited assistance with dressing and extensive assistance with toilet use and personal hygiene. R2's MDS indicated R2 was not steady with walking and turning around but was able to stabilize without staff assistance.

R2's quarterly Minimum Data Set (MDS) dated, 4/24/21, identified R2 had moderate cognitive impairment and mild depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and had diagnosis of schizoaffective bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

R2's annual Care Area Assessment (CAA) dated 1/22/21, triggered cognitive loss, psychosocial wellbeing, mood state, behavior symptoms, falls, and psychotropic drug use.

R2's Care Plan dated 7/21, indicated R2 was on psychotropic medications related to R2's schizophrenia and anxiety. R2's care plan directed staff to monitor, document, and report adverse reactions of psychotropic medications which included unsteady gait, tardive dyskinesia (causes repetitive, involuntary movements), extrapyramidal symptoms (EPS: shuffling gait, rigid muscles, and shaking) every shift.

R2's Order Summary dated 6/23/21, indicated R2 was on Abilify (medication to treat schizophrenia, bipolar disorder, and depression) 20 milligrams (mg) by mouth in the morning, divalproex (medication to treat seizures and bipolar disorder) 500 mg in the morning, divalproex 1000 mg at bedtime, escitalopram (medication to treat depression and anxiety) 15 mg at bedtime,

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risperidone (mediation used to treat certain mental and mood disorders) 4 mg at bedtime, and trazodone (medication used to treat depression and anxiety) 100 mg at bedtime. R2's order summary indicated R2 had an increase in Lexapro on 4/12/21.

R2's Dyskinesia Identification System Condensed User Scale (DISCUS) dated 11/11/20, indicated R2 had probable traditive dyskinesia showing signs of chewing or lip smacking, tongue tremor, and puckering or sucking. R2's DISCUS further indicated R2 was due for a review on 5/21. R2's record lacked documentation for DISCUS for 5/21.

During an observation on 7/12/21, at 11:00 a.m. R2 was sitting slumped forward asleep in the dining room chair. At 11:15 a.m. staff woke her up for lunch. R2 walked to the table with a shuffled gait (appears as if the person is dragging their feet as they walk), puckering of lips, and slurred speech when talking with table mates. R2 fell asleep again at 11:20 a.m. and staff had to wake her up when lunch was being served. At 11:30 a.m. R2 got up from the dining table and walked with a shuffled gait to the patio where she sat down and fell asleep again.

R2's Progress Note (PN) for July 2021, lacked documentation of side effects from anti-psychotropic medications of falling asleep during meals, shuffled gait, slurred speech, lip smacking, or puckering of lips.

R3
R3's admission MDS dated 1/2/20, indicated R3 was independent in personal hygiene, toilet use,

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dressing, walking, transfers between surfaces, and bed mobility. R3 required physical help with bathing.

R3's annual MDS dated 1/22/21, indicated R3 required extensive assistance in bed mobility, transfers, dressing, and personal hygiene. R3 MDS further indicated R3 was not steady during transitions or walking but was able to stabilize self without assistance.

R3's quarterly MDS dated 6/23/21, identified R3 was cognitively intact, had moderately severe depression, and had schizoaffective bipolar disorder. R3's MDS further indicated R3 had two or more falls since the prior assessment.

R3's Fall Risk Assessment dated 6/23/21, indicated R3 had one to two falls in the last three months, balance was unstable when making turns, and had three or more predisposing conditions.

R3's annual CAA dated 12/21/20, triggered cognitive loss, psychosocial wellbeing, mood state, falls, and psychotropic drug use.

R3's Care Plan dated 7/21, indicated R3 was on psychotropic medications related to R3's schizophrenia and anxiety. R3's care plan directed staff to monitor, document, and report adverse reactions of psychotropic medications which included unsteady gait, traditive dyskinesia, extrapyramidal symptoms (EPS: shuffling gait, rigid muscles, and shaking) every shift.

R3's Order Summary dated 7/14/21, indicated R3 was on amitriptyline (mediation used to treat depression) 50 mg at bedtime, clonazepam

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(medication used to treat seizures, panic disorder, and anxiety) 1 mg at bedtime, divalproex sodium 250 mg a day, divalproex sodium 375 mg a day, divalproex sodium 500 mg at bedtime, and paliperidone (medication used to treat schizophrenia and schizoaffective disorder) 9 mg once a day. R3's Order Summary further indicated R4 had amitriptyline added on 6/29/21, every night at bedtime; in addition, on 1/21/21, Depakote Sprinkles were written for 250 mg once a day, 375 mg once a day, and 500 mg once a day.

R3's Pharmacy Consult dated 6/28/21, indicated facility nursing staff were notified that R3 was due for DISCUS. R3's last documented DISCUS was completed on 9/25/20, and further indicated DON and provider would collaborate on DISCUS assessment at ongoing psychiatric visits.

R3's PN dated 7/1/21, at 12:06 p.m., indicated R3 presented with Parkinsonism like adverse effects with shuffled gait and mask like expression. R3's progress note lack further indication of Parkinsonism (tremor, slow movement, impaired speech or muscle stiffness) like effects or notification to primary provider.

During an observation on 7/12/21, at 11:12 am. R3 was walking into the dining room with a quick short, shuffled gain, arms were stiff and rigid next to R3's body. R3 was observed getting up and down five times prior to being served lunch and required staff to provide guidance back to the table. When R3 responded to staff about dressing, R3 spoke very quietly, and staff asked multiple times for R3 to repeat his answer.

During an observation on 7/12/21, at 2:45 p.m.

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R3 was walking into the dining room with a quick, short, shuffled gait, and his arms were stiff and rigid next to his body.

During an observation on 7/14/21, at 11:20 p.m. R3 walked out of his room with a quick short, shuffled gait, and his arms were stiff and rigid next to his body.

R4
R4's annual Functional Status MDS dated 9/4/19, indicated R4 was steady at all times while walking and turning around. R4's MDS indicated R4 was independent in bed mobility, transfers, and walking. R4's MDS further indicated R4 required supervision for dressing, eating, toileting, bathing, and personal hygiene.

R4's annual MDS dated 8/24/20, indicated R4 was steady at all times when walking, and turning around. R4 MDS further indicated R4 was not steady with moving from a seated position, moving on and off the toilet, and transfer from surfaces. R4 required supervision only for toilet use, personal hygiene, eating, and walking. R4 was independent with bed mobility and transfers, and limited assistance with dressing. R4's annual MDS indicated R4 had two or more falls since the prior assessment.

R4's quarterly MDS dated 5/27/21, included severe cognitive impairment with diagnoses including dementia and Parkinson's disease. R4 had signs and symptoms of delirium, inattention and disorganized thinking, hallucinations, and delusions. R4 required supervision and oversight for transfers and ambulation and the assistance of one person. R4 had two or more falls since the prior assessment. R4's quarterly Functional

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F 758	Continued From page 27 Status MDS dated 5/27/21, indicated R4 was not steady while moving from a seated position, walking, turning around, and moving on and off the toilet. R4 required extensive assistance with dressing, toilet use, and personal hygiene. R4's annual CAA dated 8/24/20, indicated R4 triggered psychotropic drug use, mood state, behavior symptoms, delirium, and cognitive loss. R4's care plan identified R4 had impaired cognitive function, impaired thought processes and long and short-term memory deficit. R4's Order Summary dated 7/13/21, indicated R4 was on hydroxyzine 10 mg at bedtime as needed, hydroxyzine (a medication used to treat anxiety) 10 mg at bedtime, sertraline (a medication used to treat depression) 100 mg once a day, and Sinemet (a medication to treat Parkinson's disease) 25-100 mg twice a day. R4's Order Summary indicated R4 had a increase in Sinemet and Sertaline on 1/13/21; an increase in Sertraline on 4/13/21, and hydroxyzine was started in 6/21. R4's Pharmacy Consult dated 5/28/21, indicated R5 was seen in emergency room for a fall. On 5/10/21, psychiatry directed for R5 to be seen by Neurology prior to further changes in psychotropic medications. R4's Treatment Administration Record (TAR) dated 7/21, indicated R5 was to be monitored for antipsychotic medication side effects. R4's TAR printed on 7/2/21, lacked documentation of monitoring for side effects from antipsychotic medications.	F 758		

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F 758	Continued From page 28 R4 had no AIMS assessment completed by the facility. During an observation on 7/12/21, at 11:13 a.m. R4 was walking into dining room with his eyes wide open, arms down to sides tight against legs, pill rolling (trying to roll a pill or another small object between your thumb and index finger), tremors in both hands, and an unsteady shuffled gait as he walked into the dining room. R4 was observed tongue thrusting (tongue sticks out between the teeth) throughout lunch. During an observation on 7/13/21, at 2:00 p.m. R4 was walking into dining room with a slow shuffled gait, eyes wide open, and his arms down to his sides. R4 turned around to walk back up the stairs and had a sudden freeze in movement; his feet appeared to be stuck to the step, and he reached out for the railing to catch his balance. During an observation on 7/14/21, at 11:00 a.m. R4 was walking down the stairs, staring straight forward. R4 walked into the dining room to turn around, almost losing his balance, and started to walk back up the stairs at a slow pace. R5 R5's quarterly MDS dated 6/3/21, indicated R5 was moderately cognitively impaired, and had diagnosis of paranoid schizophrenia and dementia. R5's annual CAA dated 8/31/20, triggered delirium, cognitive loss, psychosocial wellbeing, and mood state, behavior symptoms, falls, and psychotropic drug use.	F 758		

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F 758	Continued From page 29 R5's Care Plan dated 6/17/21, indicated R5 used psychotropic medications related to paranoid schizophrenia and depression. R5's care plan directed staff to monitor, document, and report adverse reactions of psychotropic medications which included unsteady gait, traditive dyskinesia, extrapyramidal symptoms (EPS: shuffling gait, rigid muscles, and shaking) every shift. R5's Fall Risk Assessment dated 6/12/21, indicated R5 had a normal balance, gait, and no predisposing conditions of deconditioning, neurological, or parkinsonism. R5's Falls risk assessment further indicated R5 had one to two falls in the last three months R5's Fall Risk Assessment dated 6/30/21, indicated R5 had three or more falls in the last three months, balance problems while walking, and had three or more predisposing conditions. R5's Order Summary dated 7/13/21, indicated R5 was on clozapine (medication used to treat schizophrenia) 100 mg in the morning, clozapine 200 mg at bedtime, escitalopram 10 once a day, lorazepam 0.5 mg twice a day, quetiapine 50 mg at bedtime. R5's DISCUS report dated 10/20/20, indicated R5 had severe puckering/thrusting of lip, tongue thrusting, shoulder torsion, and ankle flexion/foot tapping. R5's DISCUS report further indicated R5 had persistent traditive dyskinesia and was due for another DISCUS assessment 4/21. Facility did not provide a DISCUS assessment for 4/21 or after. R5 had no AIMS assessment completed by the facility.	F 758		

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R5's Pharmacy Consult dated 6/28/21, indicated R5's last DISCUS was completed on 10/20/20, and further indicated DON and provider would collaborate on DISCUS assessment at ongoing psychiatric visits.

R5's Treatment Administration Record (TAR) dated 7/21, indicated R5 was to be monitored for antipsychotic medication side effects. R5's TAR identified on July 2nd, July 4th, and on July 10th no documentation of staff completing monitoring for side effects from antipsychotic medications.

During observation on 7/12/21, at 3:00 p.m. R5 was walking into the dining room with a slow shuffled gait, pursed lip smacking, abnormal outward tongue movement, and tremors in both hands. R5 attempted to speak, but his voice was soft spoken and his words could not be understood.

When interviewed on 7/12/21, at 12:30 p.m. registered nurse (RN)-A agreed that R2 was exhibiting a shuffled gait, tongue pressing out, and lethargy. RN-A verified R3 was walking with a quick shuffled gait and stiffness in his upper extremities. RN-A stated R4 was walking with a shuffled gait, unsteady when walking, protruding eyes, dry mouth, pill rolling in both hands, and was difficult to understand. RN-A stated R5 seemed "off", appeared lethargic, difficult to hear, tongue protruding and rolling, also R5 had a shuffled gait. RN-A further stated she was unsure if they symptoms are related to side effects of anti-psychotic medications and stated she would refer to the director of nursing (DON). RN-A stated she was unable to find documentation in R2, R3, R4 chart of side effects from medication.

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When interviewed on 7/12/21, at 2:00 p.m. the DON stated nursing staff should provide daily monitoring of anti-psychotropic medication. The DON verified R2, R3, R4, and R5 were exhibiting side effects from the anti-psychotropic medications. The DON further stated if a resident was having side effects from the anti-psychotropic medications, nursing staff were to document in the resident's chart. The DON stated (RN)-A had not documented the side effects R2, R3, R4, and R5 exhibited that day. The DON further stated her expectations were for nursing staff to document side effects with each shift and report concerns to her.

When interviewed on 7/12/21, at 3:33 p.m. the facility's consultant pharmacist (CP)-A stated the facility staff were supposed to document side effects from psychotropic medications in the resident's chart. (CP)-A further stated she relied on documentation in the resident's chart and input from the DON, during recommendations during medication review. (CP)-A stated residents can experience side effects such as movement dysfunction, dystonia (continuous spasms and muscle contractions), akathisia (motor restlessness), rigidity, bradykinesia (slowness of movement), tremor, and TD, movement of the jaw, lips and tongue, sleepiness, and slowness, weight gain, orthostatic hypotension, and seizures. (CP)-A further stated it was important for residents taking these medications to be monitored and side effects documented or reported so physicians could provide ongoing guidance. (CP)-A stated the DON never reported medication concerns or side effects: TD, pill rolling, shuffled gait, rigidity, or movements of the lip or tongue during monthly

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medication review. (CP)-A stated she reviewed the residents' chart for progress notes for signs of adverse effects from anti-psychotropic medications.

When interviewed on 7/13/21, at 12:15 p.m. medical doctor (MD)-A stated his expectation for nursing would be to monitor residents for side effects of psychotropic medications and report concerns to the provider. MD-A further stated the primary care providers take recommendations from the mental health professionals regarding medication management of psychotropic medications. MD-A further stated, the facility was on the third mental health providers in a one and a half, and it was important for residents with mental health disorders to have consistent psychiatric services. MD-A stated routine visits were made mainly over video due to COVID-19 over the last year and it was difficult to see the whole person over video; and the physicians rely on the nurse's documentation and reports for concerns of adverse side effects to medication such as an increase in Parkinsonism symptoms.

When interviewed on 7/13/21, at 1:00 p.m. the facility's mental nurse practitioner (NP)-A stated she recently had taken over providing mental health services at this facility and had only held telehealth video visits due to COVID-19. NP-A stated she had not received reports or concerns for side effects of medications for R2, R3, R4, or R5. NP-A further stated at her last telehealth visit with R2, R3, R4, and R5 she did not see signs of concerns for medication side effects. NP-A stated her expectation for facility staff would be to monitor residents for side effects such as stiff extremities, shuffled gait, slurred speech, tongue protruding, pill rolling, or unsteady gait. NP-A

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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 758	Continued From page 33 further stated side effects needed to be documented and reported to the provider especially if a provider was doing telehealth visits. NP-A stated her role was to provide guidance on the medication for mental health diagnosis to help manage symptoms but not to over sedate or increase side effects which could cause a decreased function in activities of daily living and increase risk for falls. NP-A further stated the symptoms of stiff extremities, shuffled gait, slurred speech, tongue protruding, pill rolling, excessive sleepiness, and unsteady gait were concerning for too much anti-psychotropic medications. The facility's Administration of Psychotropic Medication policy dated 1/07, identified the facility would provide regular review of continued need, appropriate dosage, side effects, risk, and benefits. The facility's policy directed nursing staff to monitor psychotropic drug use daily noting any adverse effects such as increased somnolence or functional decline.	F 758		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: E06M11

Dear Administrator:

The above facility was surveyed on July 12, 2021 through July 15, 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:

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 07/15/2021

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LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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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 7/12/21, until 7/15/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5606016C (MN007438) with a licensing order issued at 0265 and 1290. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify a resident's representatives (family and case manager) when a resident had an elopement from the facility for 1 of 3 residents (R1) who were reviewed for notification of changes. Findings include: R1's Face Sheet dated 7/13/21, indicated diagnoses of dementia, depression, schizoaffective disorder and anxiety disorder. The Face Sheet also indicated family member (FM)-G and case manager (CM)-H were R1's contacts. R1's annual Minimum Data Set (MDS) dated 5/23/21, indicated severe cognitive impairment. R1 walked in his room and in the corridor independently. R1 did not require a device for mobility. The MDS indicated R1's family or guardian did not participate in R1's MDS assessment. R1's Physician Orders dated 7/13/21, indicated to complete a wander risk scale monthly and to wear a Keruve GPS Watch. R1's care plan dated 8/30/19, indicated R1 enjoyed health walks and should be encouraged to take his health walks on the deck and/or walk with staff. Staff were to encourage R1 was a high elopement risk and wanderer due to his impaired safety awareness and dementia; R1's last elopement was on 6/30/21.	2 265		

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2 265	Continued From page 4 R1's Falls/Incident Report dated 6/30/21, indicated R1 eloped from the facility because he wanted to go on a "health walk." The Falls/Incident report indicated staff noted R1 was missing and conducted a whole house search. The Keruve GPS watch indicated R1 was within the two block radius of the facility therefore staff went to go find him. R1 was redirected back to the facility. The incident report indicated the R1's doctor was notified when R1 elopement. There was no indication R1's guardian or family/friend were notified. R1's initial Activity Evaluation dated 5/21/19, indicated R1's family members (FM)-G and FM-I were very involved and R1 felt grateful. During an interview on 7/13/21, at 11:27 a.m. FM-G stated he had not been notified that R1 had had an elopement since last year. FM-G stated R1's memory was bad and he was concerned as R1 did not know his way around. During an interview on 7/13/21, at 12:54 p.m. R1's case manager (CM)-H stated she had not been notified if R1 had an elopment.CM-H stated she would want to know if R1 was lost in the community and if R1 was noted to not be safe. During an interview on 7/15/21, at 10:14 p.m. R1 stated he would like FM-G and FM-I to know if something happened to him. During an interview on 7/13/21, at 2:59 p.m. the director of nursing (DON) stated R1 had severe cognitive impairment and poor judgement. The DON stated R1 represented himsef and had they not done anything to find R1 a representative. The DON verifeid she did not contact R1's case	2 265		

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2 265	Continued From page 5 manager or family after R1's elopement. The DON further stated R1 was his own decision maker but would ask R1 if it was ok to contact FM-G and FM-I if there was an incident. The DON verified she did not ask R1 if she could contact FM-G and FM-I about his elopement which she should have due to his cognition. Also, the DON stated she maybe should have contacted CM after R1's elopement as well. A policy on notification of changes was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to notification of changes. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individuals representatives are notified and systems are in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required.	21290		

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21290	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were seen every 30 days for the first 90 days and every 60 days there after for 2 of 3 residents (R2, R3) reviewed for physician visits. Findings include: R2 R2's Face Sheet dated 7/13/21, indicated diagnoses of schizoaffective disorder, diabetes mellitus (DM) type 2, asthma, hyperlipidemia, Hypertension (HTN), chronic obstructive pulmonary disease (COPD), and chronic kidney disease (CKD) stage three. R1 admitted on 1/12/11. R2's After Visit Summery dated 1/3/20, indicated R2 was seen by her provider. Documentation of a provider visit between 1/3/20, until 6/12/20, was requested but was not provided. R2's After Visit Summery dated 6/12/20, indicated R2 was seen by her provider. R2's After Visit Summery dated 1/15/21, indicated R2 was seen by her provider. R2's After Visit Summary dated 4/2/21, indicated R2 was seen by her provider. During an interview on 7/14/21, at 12:46 p.m. the director of nursing (DON) stated there had been no provider visit for R2 between 1/15/21, and 4/2/21. The administrative assistant (AA) and DON verified it had been 77 days from when R2	21290		

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21290	Continued From page 7 was seen on 1/15/21, until 4/2/21. The DON verified R2 should have been seen within 60 days. During an interview on 7/14/21, at approximately 12:49 p.m. the DON stated she was not able to find a provider visit between 1/3/20, and 6/12/20. The DON stated she would provide one if one was found. The DON verified R2 should have been seen within 60 days. The DON did not provide documentation of a provider visit for R2 from 1/3/20, until 6/12/20. R2 was not seen by a provider for 161 days. R3 R3's Face Sheet dated 7/14/21, indicated diagnoses of insomnia, constipation, depression, anxiety, obsessive compulsive disorder (OCD), and schizoaffective disorder. The Face Sheet also indicated R3 admitted on 12/9/19. R3's Provider Progress note dated 12/16/19, indicated R3 was seen by his provider. R3's Provider Progress note dated 1/14/20, indicated R3 was seen by his provider. R3's Provider Progress note dated 3/23/20, indicated R3 was seen by his provider. R3's Provider Progress note dated 5/15/20, indicated R3 was seen by his provider. R3's Provider Progress note dated 8/11/20, indicated R3 was seen by his provider. During an interview on 7/14/21, at 12:52 p.m. the administrative assistant asked the DON if R3 was seen by the provider in 2/2020. The DON told the AA that he was seen by psychiatry but not his	21290		

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21290	Continued From page 8 provider. The AA stated it had been 69 days from when R3 was seen on 1/14/20, until 3/23/20. The DON verified R3 should have been seen every 30 days for the first 90 days. The DON also verified the their facility Physician Visit policy needed to be updated to reflect this. During an interview on 7/14/21, at approximately 12:55 p.m. The administrative assistant and DON stated R3 should have been seen every 60 days. The AA and DON verified that it had been greater than 60 days from R3's physician visit on 5/15/20, until 8/11/20. R3 was not seen by a provider for 88 days between 5/15/20, and 8/11/20. The facility Physician Visits policy dated 10/1995, indicated residents would receive ongoing 60 day check ups after their admission examination. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and procedures are developed to ensure residents are seen by their physician frequently. The facility could educate staff on these policies and perform routine evaluations of physician visits to ensure residents are seen by their provider timely. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21290		