

#### Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Lake Minnetonka Care Center		Report Number: H5606007	Date of Visit: December 21 and — 22, 2016		
Facility Address: 20395 Summerville Road Facility City:			Time of Visit: 9:30 a.m. to 6:15 p.m. 8:00 a.m. to 3:00 p.m.	Date Concluded: August 28, 2017	
Deephaven			Investigator's Name and Title:		
State: Minnesota	<b>ZIP:</b> 55331	County: Hennepin	Arthur Biah, RN, Special Investigator		

Nursing Home

#### Allegation(s):

It is alleged that a resident was neglected when the facility did not adequately supervised the resident. The resident walked onto a frozen lake in inclement weather without proper clothing. Law enforcement found the resident who expressed suicidal ideation.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ▼ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- X State Statutes Chapters 144 and 144A

#### Conclusion:

Based on preponderance of evidence, neglect occurred when facility failed to assess the community safety needs and supervise the resident. The facility did not develop a care plan to address the resident's safety and supervision. The resident eloped from the facility on two occasions. On the first occasion, the resident eloped and was found at a police station. On the second elopement, the resident was found on an ice-covered lake. The resident was hospitalized for hypothermia, a suicide attempt, and psychiatric treatment for three weeks.

The resident was admitted to the facility with schizoaffective disorder, mild cognitive impairment, and bipolar disorder. The resident ambulated independently.

Facility policy indicated each resident would be assessed for elopement and safety to determine if they could leave the grounds without supervision. The facility did not assess the resident to determine the elopement risk or need for supervision to leave the grounds.

Two months after admission to the facility, the resident became increasingly delusional and paranoid making several phone calls to law enforcement and emergency services. The resident attempted to leave the facility, citing costs and lack of insurance as reasons not to return. Staff administered medication per physician's order, but the resident's behavior continued to increase despite the medication and redirection.

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The first time the resident left the facility's grounds without staff knowledge, s/he walked to the police station almost half a mile away. The staff called the police station and found out the resident was at the police station. The police transported the resident back to the facility.

After the first elopement, the facility still did not assess the resident for elopement and safety risk. The facility still did not have a care plan and adequate changes were not implemented to prevent the resident's future elopement and safety needs.

Three days later, the resident attempted to leave the facility. The nurse on duty redirected the resident by asking him/her to stay for breakfast and the resident agreed. The resident continued to pace back and forth for most of the day. The nurse stated that given the resident's continued pacing, s/he knew the resident was at high risk of elopement. The nurse instructed the nursing assistant to closely monitor the resident to prevent elopement. The nurse stated the resident left without the knowledge the staff on duty. Both staff members were not aware of the resident's elopement until the local law enforcement notified them by phone. The nurse stated she immediately notified the DON and the administrator about the resident's elopement.

Police record review indicated the resident was found on thin ice on a lake. The resident had hypothermia, stated s/he wanted to end his/her own life, and was taken to hospital.

Hospital records indicated the resident was seen in the emergency department for hypothermia and suicidal ideation. The resident was admitted to the inpatient unit for psychiatric treatment for 23 days.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

Abuse Neglect Financial Exploitation

Substantiated Not Substantiated Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the Individual(s) and/or Facility is responsible for the

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

The facility did not assess, monitor, and supervise the resident for safety based on its Community

Assessment/Safety and Vulnerable Adult Abuse Prevention policies.

☑ Neglect ☐ Financial Exploitation. This determination was based on the following:

☐ Abuse

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Compliance:
Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.
Deficiencies are issued on form 2567: ▼ Yes □ No
(The 2567 will be available on the MDH website.)
State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.
State licensing orders were issued:    Yes    No
(State licensing orders will be available on the MDH website.)
State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.
State licensing orders were issued: 🗵 Yes 🗌 No
(State licensing orders will be available on the MDH website.)
State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 & 144A were not met.
State licensing orders were issued: 🗵 Yes 🗌 No
(State licensing orders will be available on the MDH website.)
Compliance Notes:
Facility Corrective Action: The facility took the following corrective action(s):
Definitions:

#### Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
  - (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health

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or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

#### Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

#### The Investigation included the following:

<u>Document Review</u>: The following records were reviewed during the investigation:

- ▼ Medical Records
- | Medication Administration Records
- Nurses Notes
- **X** Assessments
- Physician Orders
- X Treatment Sheets
- Physician Progress Notes
- X Care Plan Records
- ▼ Facility Incident Reports
- **X** Activities Reports
- X Other, specify:

#### Other pertinent medical records:

X Hospital Records X Police Report

#### Additional facility records:

**X** Resident/Family Council Minutes

Staff Time Sheets, Schedules, etc. ▼ Facility Policies and Procedures Number of additional resident(s) reviewed: Three Were residents selected based on the allegation(s)? Yes  $\bigcirc$  No  $\bigcirc$  N/A Specify: Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation? Yes No  $\bigcirc$  N/A Specify: Hospitalized Interviews: The following interviews were conducted during the investigation: Interview with complainant(s) 

Yes  $\bigcirc$  No  $\bigcirc$  N/A Specify: If unable to contact complainant, attempts were made on: Date: Time: Time: Date: Date: Time: Interview with family: Yes O No N/A Specify: Estranged from family Did you interview the resident(s) identified in allegation: No ○ N/A Specify: Hospitalized Did you interview additional residents? (•) Yes O No Total number of resident interviews:Three Interview with staff: 

Yes  $\bigcirc$  No  $\bigcirc$  N/A Specify: Tennessen Warnings Tennessen Warning given as required: 

Yes O No Total number of staff interviews: Six Physician Interviewed: Yes No Nurse Practitioner Interviewed: Yes No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s): O Yes  $\bigcirc$  No N/A Specify: Attempts to contact: Date: Time: Date: Time: Date: Time: If unable to contact was subpoena issued: Yes, date subpoena was issued O No

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Were contacts made with any of the following:

Facility Name: Lake Minnetonka Care Center Report Number: H5606007 ☐ Emergency Personnel 🗵 Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: Personal Care Nursing Services **X** Cleanliness ▼ Dignity/Privacy Issues ▼ Safety Issues **X** Facility Tour x Injury Was any involved equipment inspected: () Yes O No N/A Was equipment being operated in safe manner: Yes O No N/A Were photographs taken: O Yes Specify: No cc: **Health Regulation Division - Licensing & Certification Minnesota Board of Examiners for Nursing Home Administrators** The Office of Ombudsman for Mental Health and Developmental Disabilities The Office of Ombudsman for Long-Term Care **Hennepin County Attorney Deephaven Police Department Deephaven City Attorney** 



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 14, 2017

Mr. Jeff Sprinkel, Administrator Lake Minnetonka Care Center 20395 Summerville Road Deephaven, MN 55331

RE: Project Number H5606007, S5606027

Dear Mr. Sprinkel:

On August 3, 2017, as authorized by the CMS Region V Office, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective June 18, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 12, 2017. (42 CFR 488.417 (b))

In addition, on August 3, 2017, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

•Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Further, this Department notified you in our letter of August 3, 3017, 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 September 12, 2017.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on June 12, 2017 and a standard survey completed on July 13, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On August 22, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR), on September 11, 2017 and October 19, 2017, the Minnesota Departments of Health and Public Safety completed a PCR by review of the plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on June 12, 2017 and a standard survey completed on July 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 10, 2017. Based on our visit, we determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on June 12, 2017 and standard survey completed July 13, 2017, as of September 10, 2017.

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As a result of the revisit findings, we are discontinuing the Category 1 remedy of state monitoring, as of September 10, 2017.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letter of August 3, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of this action:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 12, 2017, be rescinded. (42 CFR 488.417 (b))

Further, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy recommended in our letter of August 3, 2017:

•Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 12, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 12, 2017, is to be rescinded.

In our letter of August 3, 2017, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 12, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 10, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 01/10/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		245606	B. WING			08/	22/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD		
LAKE MI	NNETONKA CARE C	ENTER			DEEPHAVEN, MN 55331		
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{F 000}	INITIAL COMMEN	TS	{F 0	00}			
	August 22, 2017, to issued relate to cor Minnetonka Care C	n revisit was conducted on o follow up on deficiencies mplaint H5606007. Lake Center is in compliance with 42 part B, requirements for Long s.				* *	
	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.					
							(Ve) DATE
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		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.

PRINTED: 06/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			} ` '		(X3) DATE SURVEY COMPLETED		
		245606	B. WING			ł	C <b>12/2017</b>
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LAKE M	INNETONKA CARE C	ENTER		20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331			
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F 000	INITIAL COMMEN	TS	F 00	00			
F 225 SS=D	to investigate case following deficienci	1)-(4) INVESTIGATE/REPORT	F 22	25			
	483.12(a) The facil	ity must-					
	(3) Not employ or o who-	therwise engage individuals					
		d guilty of abuse, neglect, propriation of property, or court of law;			1		
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or					
	or her professional body as a result of	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.					
	licensing authorities actions by a court o	ate nurse aide registry or s any knowledge it has of f law against an employee, e unfitness for service as a facility staff.			,		
		llegations of abuse, neglect, reatment, the facility must:					
		lleged violations involving loitation or mistreatment,					
AROBATORY	DIDECTOR'S OF PROVID	ا ER/SUPPLIER REPRESENTATIVE'S SIGN	ATLIDE	TITLE		- 1	(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 225	including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that cause abuse and do not rethe administrator of officials (including to adult protective senfor jurisdiction in lor accordance with Staprocedures.  (2) Have evidence the thoroughly investigation is in procedures.  (3) Prevent further pexploitation, or mist investigation is in procedures administrator or his representative and with State law, incluing Agency, within 5 woif the alleged violation corrective action muthis REQUIREMENTS.  Based on documer facility failed to immediate after the alleged on documer facility failed to immediate after the alleged to immediate after the alleged on documer facility failed to immediate after the alleged to immediate after the alleged on documer facility failed to immediate after the alleged on the alleged or immediate after the alleged on documer facility failed to immediate after the alleged or immediate	unknown source and resident property, are ly, but not later than 2 hours is made, if the events that in involve abuse or result in r, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides and the law through established that all alleged violations are sted.  In the state Survey Agency and vices where state law provides and the law through established that all alleged violations are sted.  In the state Survey are state law provides are sted and the state sted and the state sted are sted and the state sted and the state survey of the state survey of the state survey of the incident, and the state sterified appropriate	F 2	225	,		
	one of four resident eloped from the faci first elopement, R1 On the second elop	s, (R1) reviewed, when R1 ility on two occasions. On the was found at a police station. ement, R1 was found on a d suicide, had hypothermia,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	COMPLETED		
		245606	B. WING	i		C 06/12/2017	
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F 225	and was hospitalized. Findings include: R1's medical record diagnoses included paranoid state, mile bipolar disorder. R1 hospital dated Octowas admitted on Octowas admitted by Asindicated a Pre-Adm (PAS), completed by facility placement de PAS indicated that I cueing and redirect week. The PAS also forgetfulness and we self from harm or de Nursing progress no indicated R1 wanted worried about the correct parameters.	d was reviewed. R1's schizoaffective disorder, decognitive impairment, and s's discharge summary from ber 31, 2016 indicated R1 ctober 13, 2016 for delusions. Ons to the facility required R1 sychiatrist and psychologist.  The cord indicated the facility hission Screening Assessment by the hospital, for nursing atted October 28, 2016. The R1's behavior needed staff's ion four or more times per or indicated that R1 had minor was mentally unable for protect	F2	225			
	could afford living the wanted to walk on fagreed and told R1 The DON told R1 the was five degrees Fagpropriately. R1 with the facility grounds, had eloped, she was the local police depondent of the was a second to wante the local police depondent.	nere. R1 insisted that s/he acility's grounds. The DON to stay on facility's grounds. The outdoor temperature ahrenheit and R1 was dressed ent outside and eloped from When the DON realized R1 ited 20 minutes, and called artment. The police informed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 225	R1 showed up at the mile from the facility to turn him/herself iterrorist organization back to the facility.  Nursing progress nuindicated after R1's	e police station, which was 0.4 y. R1 told police s/he wanted n for possible affiliation with n. The police transported R1 ote dated December 14, 2016 was brought back to the	F 2	225			
	and kept them at nu from leaving the fact dangerous weather.  Police report dated a police officer and found R1 on a lake negative seven degreport indicated R1 suffered hypotherm hospital.	December 17, 2016 indicated a county water patrol officer wearing jeans and a t-shirt in ree fahrenheit weather. The expressed suicide ideation, ia, and was transported to a					
	1:00 p.m. and state December 14 and 1 facility did not repor agency and did not December 14 and 1 know why the facility agency or investigated R1 was not a The DON stated state	viewed December 21, 2016 at d that R1 eloped on 7, 2016. The DON stated the t R1's elopement to the state investigate how R1 eloped on 7, 2016. The DON did not y did not report to state te the incident. The DON assessed for elopement risks. affs were expected to monitor r buzzer when residents leave e facility.		The state of the s			
	21, 2016 at 1:15 p.r not report R1's elop 17, 2016 to state ag	ras interviewed on December n. and stated the facility did ements on December 14 and ency and did not complete an n. Administrator also stated he					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245606	B. WING			C <b>06/12/2017</b>	
	PROVIDER OR SUPPLIER	ENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	, <u> </u>	12/2017
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F 225	was aware the faci residents' safety. T door buzzer was su	age 4 lity was responsible for he administrator stated that ufficient for monitoring the ot want to take their freedom	F 2	25			
	December 21, 2010 staffs were expected when residents corn RN-D stated she w	RN)-D was interviewed on at 4:30 p.m. and stated that at the to respond to door buzzer ne in or leave to go outside. as aware of R1's elopement 016 and was told to closely elopement risk.					
	January 9, 2017 at responding to door most residents's ind and staff engagement she was unaware of elopement. RN-F s when R1 eloped on found at the lake, h	RN)-F was interviewed on 3:46 p.m. and stated that buzzer was difficult due to dependence with ambulation ent with care. RN-F stated that of R1's December 14, 2016 tated that she was working December 17, 2016, was ad hypothermia and was N-F stated she did not report ency.					
F 226 SS=D	Adults Protection P indicated that must possible abuse or r facility's policy and components for scr and identification of exploitation of resident property. 483.12(b)(1)-(3), 48	procedure titled Vulnerable olicy dated February 2001 report and investigate reglect of any resident. The procedure did not include eening, training, prevention abuse, neglect, and ent, and misappropriation of 33.95(c)(1)-(3)	F 2:	26			

AND PLAN OF CORRECTION   X(1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   A. BUILDING   A. BUILDING			COMPLETED					
		245606	B. WING	i		C <b>06/12/2017</b>		
	PROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331					
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F 226	Continued From pa 483.12 (b) The facility must written policies and	develop and implement	F2	226				
	(1) Prohibit and pre	vent abuse, neglect, and ents and misappropriation of						
	(2) Establish policies and procedures to investigate any such allegations, and							
	(3) Include training §483.95,	as required at paragraph						
	the freedom from al requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum						
		constitute abuse, neglect, sappropriation of resident at § 483.12.	1					
		or reporting incidents of abuse, , or the misappropriation of						
	prevention. This REQUIREMEN by: Based on documer facility failed to deve and procedures to r allleged violation of	nagement and resident abuse IT is not met as evidenced at review and interview, the elop and implement policies eport and investigate an neglect for one of four ewed, when R1 elopeed from						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ENTER .		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		OULD BE	(X5) COMPLETION DATE	
F 226	the facility on two of elopement, R1 was the second elopem	ge 6 ccasions. On the first found at a police station. On ent, R1 was found on a lake in le, had hypothermia, and was	F 2	26			
	Adults Protection Prindicated that must possible abuse or n facility's policy and components for scrand identification of	procedure titled Vulnerable olicy dated February 2001 report and investigate eglect of any resident. The procedure did not include eening, training, prevention abuse, neglect, and ent, and misappropriation of					
	diagnoses included paranoid state, mild bipolar disorder. R1 hospital dated Octo was admitted on Octo Discharge instruction follow up with pseudose a Pre-Adm (PAS), completed by facility placement da PAS indicated that is cueing and redirection week. The PAS also	I was reviewed. R1's schizoaffective disorder, cognitive impairment, and 's discharge summary from ber 31, 2016 indicated R1 stober 13, 2016 for delusions on to the facility required R1 ychiatrist and psychologist.  The cord indicated the facility hission Screening Assessment by the hospital, for nursing ated October 28, 2016. The R1's behavior needed staff's on four or more times per o indicated that R1 had minor as mentally unable for protect eath.					
		ote dated December 14, 2016 d to leave because s/he was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMPLETED		
		245606	B. WING			C 06/12/2017		
	PROVIDER OR SUPPLIER	ENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331	1 00.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 226	worried about the ordirector of nursing (could afford living the wanted to walk on fragreed and told R1 DON stated she tole temperature was five was dressed approperature was five was dressed approperature approperature was five was dressed approperature. The police of the facility from the facility from the police informed police station.  Police record dated R1 showed up at the mile from the facility to turn self in for poorganization. The police facility.  Nursing progress not indicated after R1's facility, DON took and kept them at nufrom leaving the facility dangerous weather.  Police report dated a police officer and found R1 on a lake negative seven degreport indicated R1 suffered hypotherminospital.  Director of Nursing of the facility of the facility.	ost of living at the facility. The DON) reassured R1 s/he here. R1 insisted that s/he acility's grounds. The DON to stay on facility's grounds. It hat the outdoor re degrees Fahrenheit and R1 oriately. R1 went outside and om the facility grounds. When ad eloped, she waited 20 the local police department. If DON that R1 was at the December 14, 2016 indicated the police station, which was 0.4 or R1 told police s/he wanted esible affiliation with terrorist police transported R1 back to the way R1's coat, hat and gloves, irsing station to prevent R1 ility without supervision in	F 2	26				
		mber 14 and 17, 2016. The						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245606	B. WING				
	ENTER		20395 SUMMERVILLE ROAD	1 00/12/2011		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	D BE COMPLÉTION	N	
DON stated the face elopement to the sinvestigate how R1 17, 2016. The DON did not report to staincident. The DON for elopement risks expected to monitor when residents lear The administrator v21, 2016 at 1:15 p. not report R1's elop 17, 2016 to state a internal investigation was aware the faci residents' safety. The door buzzer was standard to the sidents of the state of the state and the state of the state and the state of the state and the state of the	cility did not report R1's tate agency and did not eloped on December 14 and I did not know why the facility ate agency or investigate the stated R1 was not assessed at The DON stated staffs were or and respond to door buzzer we from or return to the facility.  I was interviewed on December m. and stated the facility did between and did not complete an on. Administrator also stated he lity was responsible for the administrator stated that ufficient for monitoring the	F 226				
December 21, 2010 staffs were expected when residents corn RN-D stated she won December 14, 2 monitor R1 due to a Registered nurse (I January 9, 2017 at responding to door most residents's incompand staff engagements and staff engagements are considered in the sum of the staff engagements and staff engagements. RN-F sum of the staff engagement and staff engagements are considered in the staff engagement. RN-F sum of the staff engagement and staff engagements are considered in the staff engagement.	at 4:30 p.m. and stated that ed to respond to door buzzer me in or leave to go outside. as aware of R1's elopement to 16 and was told to closely elopement risk.  RN)-F was interviewed on 3:46 p.m. and stated that buzzer was difficult due to dependence with ambulation ent with care. RN-F stated that of R1's December 14, 2016 tated that she was working December 17, 2016, was					
	Continued From particular to the stinction to the residents and did naway.  Registered nurse (I December 21, 2016 to state a internal investigation was aware the facilities away.  Registered nurse (I December 21, 2016 to state a internal investigation was aware the facilities away.  Registered nurse (I December 21, 2016 to state a internal investigation was aware the facilities away.  Registered nurse (I December 21, 2016 to state a internal investigation was aware the facilities away.  Registered nurse (I December 21, 2016 to state a internal investigation was aware the facilities away.  Registered nurse (I December 21, 2016 to state and did naway.  Registered nurse (I December 21, 2016 to state and did naway.  Registered nurse (I December 21, 2016 to state and did naway.  Registered nurse (I December 21, 2016 to state and did naway.  Registered nurse (I December 21, 2016 to state and did naway.  Registered nurse (I December 21, 2016 to state and did naway.	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  DON stated the facility did not report R1's elopement to the state agency and did not investigate how R1 eloped on December 14 and 17, 2016. The DON did not know why the facility did not report to state agency or investigate the incident. The DON stated R1 was not assessed for elopement risks. The DON stated staffs were expected to monitor and respond to door buzzer when residents leave from or return to the facility.  The administrator was interviewed on December 21, 2016 at 1:15 p.m. and stated the facility did not report R1's elopements on December 14 and 17, 2016 to state agency and did not complete an internal investigation. Administrator also stated he was aware the facility was responsible for residents' safety. The administrator stated that door buzzer was sufficient for monitoring the residents and did not want to take their freedom	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  DON stated the facility did not report R1's elopement to the state agency and did not investigate how R1 eloped on December 14 and 17, 2016. The DON did not know why the facility did not report to state agency or investigate the incident. The DON stated R1 was not assessed for elopement risks. The DON stated staffs were expected to monitor and respond to door buzzer when residents leave from or return to the facility.  The administrator was interviewed on December 21, 2016 at 1:15 p.m. and stated the facility did not report R1's elopements on December 14 and 17, 2016 to state agency and did not complete an internal investigation. Administrator also stated he was aware the facility was responsible for residents' safety. The administrator stated that door buzzer was sufficient for monitoring the residents and did not want to take their freedom away.  Registered nurse (RN)-D was interviewed on December 21, 2016 at 4:30 p.m. and stated that staffs were expected to respond to door buzzer when residents come in or leave to go outside. RN-D stated she was aware of R1's elopement on December 14, 2016 and was told to closely monitor R1 due to elopement risk.  Registered nurse (RN)-F was interviewed on January 9, 2017 at 3:46 p.m. and stated that responding to door buzzer was difficult due to most residents's independence with ambulation and staff engagement with care. RN-F stated that she was unaware of R1's December 14, 2016 elopement. RN-F stated that she was working when R1 eloped on December 17, 2016, was	DENTIFICATION NUMBER: 245606   B. WING	A BUILDING COMPLETED  245606  2 WING  245606  2 WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2039S SUMMERVILLE ROAD DEEPHAVEN, MN 55331  SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  DON stated the facility did not report R1's elopement to the state agency and did not investigate how R1 eloped on December 14 and 17, 2016. The DON stated R1 was not assessed for elopement risks. The DON stated staffs were expected to monitor and respond to door buzzer when residents leave from or return to the facility.  The administrator was interviewed on December 21, 2016 at 1:15 p.m. and stated that door buzzer was sufficient for monitoring the residents' safety. The administrator stated that door buzzer was sufficient for monitoring the residents' safety. The administrator stated that door buzzer was sufficient for monitoring the residents and did not complete an internal investigation. Administrator stated that door buzzer was sufficient for monitoring the residents and did not complete an internal investigation and stated that facility was responsible for residents' safety. The administrator stated that door buzzer was sufficient for monitoring the residents and did not complete an internal residents come in or leave to go outside. RN-D stated she was aware of R1's elopement on December 14, 2016 and was told to closely monitor R1 due to elopement risk.  Registered nurse (RN)-F was interviewed on January 9, 2017 at 3:46 p.m. and stated that responding to door buzzer was difficult due to most residents's independence with ambulation and staff engagement with care. RN-F stated that she was unaware of R1's December 14, 2016 elopement. RN-F stated that she was working when R1 eloped on December 17, 2016 elopement R1, 2016 elopement RN-F stated that she was working when R1 eloped on December 17, 2016	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245606	B. WING			C <b>06/12/2017</b>	
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	001	12/2017
				2	0395 SUMMERVILLE ROAD		
LAKE MI	NNETONKA CARE C	ENTER		D	DEEPHAVEN, MN 55331		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR E	SO IDENTIFY THIS IN CHARACTERY	IAG		DEFICIENCY)		
F 226	Continued From pa	ge 9	F 2	226			
	incident to state age	~					
F 279	483.20(d);483.21(b)	-	F 2	79			
SS=D	COMPRÉHENSIVE						
					·		
	483.20	t manintain all manidant					
		nust maintain all resident leted within the previous 15					
		ent's active record and use the					
		sments to develop, review					
		lent's comprehensive care					
	plan.	·				-	
	400.04						
	483.21 (b) Comprehensive	Care Plans					
	(b) Comprehensive	Cale Flans					
	(1) The facility must	t develop and implement a					
		son-centered care plan for					
		istent with the resident rights					
		(c)(2) and §483.10(c)(3), that					
		e objectives and timeframes			,		
		medical, nursing, and mental					
		eeds that are identified in the essment. The comprehensive					
	care plan must desc						
	out o plant made also						
		t are to be furnished to attain					
		dent's highest practicable					
		nd psychosocial well-being as			<u>.</u>		
	required under §483	3.24, §483.25 or §483.40; and					
	(ii) Any services the	t would otherwise be required					
		3.25 or §483.40 but are not					,
		resident's exercise of rights					
		uding the right to refuse					
	treatment under §48	33.10(c)(6).					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	(III) Any specialized	services or specialized					
	<u></u>						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		COM	(X3) DATE SURVEY COMPLETED		
		245606	B. WING			1	C <b>12/2017</b>
	PROVIDER OR SUPPLIER	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	1 00,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 279	rehabilitative service provide as a result recommendations. findings of the PAS rationale in the residential resid	es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.  with the resident and the tative (s)- goals for admission and  preference and potential for acilities must document at's desire to return to the sessed and any referrals to ies and/or other appropriate pose.  Is in the comprehensive care and, in accordance with the reth in paragraph (c) of this  NT is not met as evidenced and treview and interview, the elop and implement a son-centered care plan for son-cente	F 2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		245606	B. WING		06	/12/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	bipolar disorder. R hospital dated Octo was admitted on O R1's discharge insi up with psychiatrisi receiving facility.  R1's medical recor or comprehensive of cognitive loss, r status, and psycho record did not iden these care areas.  Review of facility's received a Pre-Adr (PAS), completed b facility placement o PAS indicated that cueing and redirec week. The PAS als forgetfulness and v self from harm or o The facility's activit 31, 2016 indicated same evaluation in	d cognitive impairment, and 1's discharge summary from ober 31, 2016 indicated R1 october 13, 2016 for delusions. It is tructions required R1 to follow that and psychologist at the did did not include a temporary care plan to identify care areas mood state, falls, nutritional tropic drug use. R1's medical tify goals and interventions for record indicated the facility mission Screening Assessment by the hospital, for nursing dated October 28, 2016. The R1's behavior needed staff's tion four or more times per so indicated that R1 had minor was mentally unable for protect	F 279				
·	November 2, 2016 admissions in the p psychiatric illness. anti-psychotic med progress note indice	chiatric progress note dated indicated R1 had 19 cast eleven months due to his R1 was started on new ication for psychosis. The cated R1 required facility staff's medical condition and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI			(X3) DATE SURVEY COMPLETED		
		245606	B. WING			i	C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION · DATE	
F 279			F 2	79			
	indicated R1 wante s/he was worried a	ote dated December 14, 2016 d to leave the facility because bout the cost of living at the r of nursing (DON) reassured d living there.					
	R1 showed up at the zero point four (0.4)	December 14, 2016 indicated be police station, which was mile from the facility. The R1 back to the facility.		the contract of the contract o			
	indicated DON took gloves and kept the	ote dated December 14, 2016 away R1's coat, hat and em at nursing station. DON 1 from leaving the facility ngerous weather.					
	a police officer and found R1 on a lake negative seven deg report indicated R1	December 17, 2016 indicated a county water patrol officer wearing jeans and a t-shirt in ree Fahrenheit weather. The expressed suicide ideation, ia, and was transported to a					
	p.m., director of nur not have a care pla that R1 eloped on D stated she called th back to the facility b outdoor temperatur and R1 was dresse eloped from the fac The facility did not a prevent elopement. again on December	December 21, 2016 at 12:00 rsing (DON) stated that R1 did n developed. The DON stated December 14, 2016. DON e police and R1 was brought by the police. DON stated the e was five degrees Fahrenheit d appropriately when R1 illity on December 14, 2016. assess or evaluate R1 to DON stated when R1 eloped 17, 2016, and was found at linot assess R1 for elopement				,	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	ING	COMPLETED	
		245606	B. WING	1.0.1.000.011.000.010.000.010.000.010	C 06/12/2017
	OVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COD 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLÉTION
F 323 4 5 SS=G () () () () () () () () () () () () ()	mplement a comproefore and after the nterview with regist January 9, 2017 indolan. RN-F also stand previously eloperated that should be a recompleted within or loan within thirty day 183.25(d)(1)(2)(n)(1) HAZARDS/SUPERVIOLEMENT of accidents. The facility must enterprise and assistance deviand assistance deviand assistance deviand assistance deviand assistance deviand assistance of bed to the following element of the faciliowing element of the following element of the following element and assistance of bed to the following element of the following element of the following element and assistance of the following element of the following el	he facility did not develop and ehensive care plan for R1 each elopement.  Itered nurse (RN)-F dated licated R1 did not have a care ted she was not aware that R1 ed on December 14, 2016. e got report that R1 was a ent on December 17, 2016.  Ind procedure titled Care Plan, do that each resident must have each resident must have week and a permanent care by supon admission.  I)-(3) FREE OF ACCIDENT VISION/DEVICES  Sure that -  Vironment remains as free reds as is possible; and have each experience to prevent accidents.  In facility must attempt to use investives prior to installing a side or side rail is used, the facility to installation, use, and it rails, including but not limited ments.  Ident for risk of entrapment	F 2		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				CX3) DATE SURVEY COMPLETED	
		245606	B. WING			1	12/2017	
	PROVIDER OR SUPPLIER	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 323	the resident or resident formed consent points and the appropriate for the This REQUIREMENT by:  Based on interview facility failed provides supervision to preveresidents reviewed facility two times in elopment, R1 eloped On second elopemovery cold weather was suicide attempt, shospitalized.  Findings include:  R1's medical recording includes included paranoid state, miles bipolar disorder. R1 hospital dated Octowas admitted on Octowas admitt	s and benefits of bed rails with dent representative and obtain rior to installation.  bed's dimensions are resident's size and weight. It is not met as evidenced and document review, the experience residents with adequate ent elopement for one in four (R1) when R1 eloped from the three days. On the first id and went to a police station. Ent, R1 was found on a lake in without appropriate clothing in uffered hypothemia, and was a was reviewed. R1's schizoaffective disorder, and cognitive impairment, and sidischarge summary from ber 31, 2016 indicated R1 ctober 13, 2016 for delusions. Functions required R1 to follow and psychologist at the correct or comprehensive care plants, goals and interventions for distate, falls, nutritional status, rug use.	F3	323	,			
	received a Pre-Adm (PAS), completed b	ecord indicated the facility hission Screening Assessment y the hospital, for nursing ated October 28, 2016. The						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED	
		245606	B. WING		i	C /12/2017	
	PROVIDER OR SUPPLIER			112/2017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	PAS indicated that cueing and redirect week. The PAS als forgetfulness and waself from harm or done of the facility's activition of the facility of the payon of the p	R1's behavior needed staff's tion four or more times per o indicated that R1 had minor was mentally unable for protect eath.  The sevaluation dated October that R1 preferred walking. The dicated R1 was independent 1's was characterized as shy, tious.  The dicated R1 had 19 that indicated R1 had 19 that eleven months due to R1 was started on new fication for psychosis. The ated that R1 required close cal condition and medication ation with facility staff.  The district progress note dated indicated R1's had impaired and staff to watch for triggers or changes.  The district progress note dated indicated R1's had impaired and staff to watch for triggers or changes.  The district progress note dated indicated R1's had impaired and staff to watch for triggers or changes.  The district progress note dated indicated R1's had impaired and staff to watch for triggers or changes.  The district progress note dated indicated R1's had impaired and staff to watch for triggers or changes.  The district progress note dated indicated R1 had so for the week elopement indicated R1 had so for the week e	F 3.				
	and stated the pres assassinated. The was sweating, pacin packed, and stated	the Air Force, refused shower, ident was kidnapped and progress note indicated R1 ng his/her room, had bag feeling more depressed. R1's not indicate R1's psychiatrist					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION	l <sup>(×</sup>	(X3) DATE SURVEY COMPLETED	
		245606	B. WING			C <b>06/12/2017</b>
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIF 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIA	
F 323	called back regardi paranoia, but did not facility did not assessive supervision to prevent the supervision to prevent the same ager told DON hospitalizations ever delusions and parathe hospital. R1 call the sheriff department that the kidnapped and assessive supervision to prevent the same ager told DON hospitalizations ever delusions and parathe hospital. R1 call the sheriff department that the kidnapped and assessive supervision R1 s/he could afford asked R1 wanter s/he was worried affacility. The director R1 s/he could afford asked R1 to have be outside and would repolice record dated R1 showed up at the mile from the facility. Nursing progress not indicated DON took gloves and kept the prevent R1 from leasy without supervision Review of nursing progress of indicated R1 told supervision Review of nursing progression Review of nurs	ng R1's delusions and of call the facility back. The ss R1 for adequate ent elopement and self harm.  Ote reviewed for the day pement indicated DON e manager. R1's care that R1 had cycles of my two months due to moia. R1 also wanted to go to led emergency services twice, ent stating s/he wanted to turn ed and reported to sheriff president has been asinated.  Ote dated December 14, 2016 do to leave the facility because bout the cost of living at the of nursing (DON) reassured do living there. DON stated she reakfast, but R1 wanted to go	F 3.	923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245606	B. WING			1	C <b>12/2017</b>
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICIENCY)		BE	(X5) COMPLETION DATE
F 323	December 16, 201 decaffeinated coffe	age 17 6 indicated R1 thought his/her se was caffeinated, even after sewed an individual cup for	F 3	23			
	indicated that R1 h to leave facility bed trouble. Staff reass his/her room. R1 c leave the facility ag	note dated December 17, 2016 and a packed bag and wanted cause s/he was in financial sured R1 and s/he returned to ame back later and wanted to gain. Staff stated R1 went facility's mailbox, and came					
	a police officer and found R1 on a lake negative seven de report indicated R1	December 17, 2016 indicated a county water patrol officer wearing jeans and a t-shirt in gree Fahrenheit weather. The expressed suicide ideation, nia, and was transported to a					
·	2016 indicated R1 tingling of both han	record dated December 18, had some pain, swelling and ids, blisters on right hand and pite.					
	p.m., the director of did not have a care eloped on December facility found out the on December 14, 2 the police and R1 which by the police. DON temperature was firwas dressed approache facility on December 10 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility on December 2 did not be seen as the facility of the facilit	December 21, 2016 at 12:00 f nursing (DON) stated that R1 e plan. The DON stated that R1 er 14, 2016. DON stated at R1 eloped from the property 2016. DON stated she called was brought back to the facility stated the outdoor ve degrees Fahrenheit and R1 priately when s/he eloped from the mber 14, 2016. The facility did that R1's elopement risk. DON					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245606	B. WING			1	12/2017
	PROVIDER OR SUPPLIER	ENTER					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	stated when R1 elo 2016 and was found assessed or evalua als stated that R1 dhis/her care at the faware of R1's past two due to his/her plus In interview dated J (RN)-F stated that rdifficult due to most with ambulation and RN-F also stated sh previously eloped of also stated that she risk of elopement of The facility policy are Assessment and Sa indicated a physicial indicate whether or walk off the ground facility will determine resident is appropriate community.  Facility's policy and Decompensated Red June 1991 indicated prevent an acting-or him/herself or other Facility's policy and Incident/Accident Red 1991 indicated the food and incident any incident any incident and incident any incident any incident and incident and incident any incident and incident and incident any incident and incident any incident any incident and incident and incident any incident and incident any incident and incident and incident any incident any incident and incident and incident any incident and incident and incident any incident and incident a	ped again on December 17, d at the lake, R1 was not ted for elopement risks. DON id not have care plan to guide acility. DON stated she was cycles of hospitalization every sychiatric illness.  anuary 9, 2017 at 3:46 p.m., esponding to door buzzer was residents's independence d staff engagement with care. He was not aware that R1 had in December 14, 2016. RN-F got report that R1 was a high in December 17, 2016.  Ind procedure titled Community afety dated August 2012 in's order will be obtained to not a resident is allowed to The policy also indicated the eight extent to which each ately safe to venture into the procedure titled esident Management dated deach staff member is to ut resident from injuring s.  procedure titled eporting dated November facility should report and ent or accident involving a did indicate how soon the	F3	23			
	•	•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		245606	B. WING			C <b>06/12/2017</b>	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 20395 SUMMERVILLE ROAD	, ZIP CODE	<u> </u>	12/2017
LAKE MI	NNETONKA CARE C	ENTER		DEEPHAVEN, MN 55331	-		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROP	BE	(X5) COMPLETION DATE
F 323	Facility's policy and Absence policy date facility's staff must sign in the date and left the facility.  Facility's policy and Adults Protection Pindicated that must possible abuse or nacility's policy and components for scrand identification of	ge 19 procedure titled Leave of ed July 2016 indicated that ensure residents sign out and time when they returned and procedure titled Vulnerable olicy dated February 2001 report and investigate eglect of any resident. The procedure did not include eening, training, prevention abuse, neglect, and ent, and misappropriation of	F 3:	23			



Protecting, Maintaining and Improving the Health of All Minnesotans

November 14, 2017

Mr. Jeff Sprinkel, Administrator Lake Minnetonka Care Center 20395 Summerville Road Deephaven, MN 55331

Re: Reinspection Results - Complaint Number H5606007

Dear Mr. Sprinkel:

On August 22, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on June 12, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 00234 08/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} Initial Comments {2 000} \*\*\*\*\*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:** A licensing order follow-up was completed to Minnesota Department of Health is follow up on correction orders issued related to documenting the State Licensing complaint H5606007. Lake Minnetonka was Correction Orders using federal software. found in compliance with state regulations. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing The facility is enrolled in ePOC and therefore a Homes. signature is not required at the bottom of the first The assigned tag number appears in the

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R-C B. WING 00234 08/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {2 000} Continued From page 1 far left column entitled "ID Prefix Tag." The page of the State form. Although no plan of state statute/rule number and the correction is required, it is required that the facility corresponding text of the state statute/rule acknowledge receipt of the electronic documents. out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 00234 06/12/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 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:** A complaint investigation was conducted to Minnesota Department of Health is documenting the State Licensing investigate complaint #H5606007. As a result, the following correction orders are issued. Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND I DAN	OF CONTROL	IDENTIFICATION NO.	A. BUILDING:				
		00234	B. WING		06/1	2/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
1 A 1/2 E R/II	NNETONKA CARE CI	20395 SU	MMERVILLE	ROAD			
LAKE WII	INNETONKA CARL CI	DEEPHAV	EN, MN 55	331			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 1	2 000				
	·	<b>3</b> ~ ·		The assigned tag number appears far left column entitled "ID Prefix T The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the findings, are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Methol Correction and the Time Period for Correction.	ag." the tute/rule ies" ply" his which after the s veyors d of		
·				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION OF A MINISPORTATIONS OF MINISPORTATIONS OF MINISPORTATIONS.	THIS O ON FOR		
				VIOLATIONS OF MINNESOTA ST STATUTES/RULES.	AIE		
2 305	Reporting	Incident and Accident	2 305				
	must report any acc and the nursing hor complete a detailed accident or injury a learning of the accident						
	This MN Requireme	ent is not met as evidenced	1				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED				
						С				
002		00234	B. WING		06/1	06/12/2017				
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
LAKE MINNETONKA CARE CENTER  20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331										
(X4) ID	DOMESTIC DESCRIPTION OF DESCRIPTION									
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE				
2 305	Continued From page 2		2 305							
	facility failed to immand investigate and one of four resident eloped from the factirst elopement, R1 On the second elop	at review and interview, the nediately report to state agency alleged violation of neglect for its, (R1) reviewed, when R1 was found at a police station. Dement, R1 was found on a d suicide, had hypothermia, ed.								
	Findings include:									
	diagnoses included paranoid state, mile bipolar disorder. R1 hospital dated Octowas admitted on Octobischarge instruction	d was reviewed. R1's schizoaffective disorder, I cognitive impairment, and 's discharge summary from ber 31, 2016 indicated R1 ctober 13, 2016 for delusions. Ons to the facility required R1 sychiatrist and psychologist.								
·	received a Pre-Adm (PAS), completed b facility placement d PAS indicated that l cueing and redirect week. The PAS also	record indicated the facility nission Screening Assessment y the hospital, for nursing ated October 28, 2016. The R1's behavior needed staff's ion four or more times per o indicated that R1 had minor was mentally unable for protect eath.								
	indicated R1 wante- worried about the c director of nursing ( could afford living the wanted to walk on f agreed and told R1	ote dated December 14, 2016 d to leave because s/he was ost of living at the facility. The DON) reassured R1 s/he here. R1 insisted that s/he acility's grounds. The DON to stay on facility's grounds. hat the outdoor temperature								

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** 

(X3) DATE SURVEY COMPLETED

00234

B. WING \_

С 06/12/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: \_

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			
2 305	Continued From page 3	2 305					
	was five degrees Fahrenheit and R1 was dressed appropriately. R1 went outside and eloped from the facility grounds. When the DON realized R1 had eloped, she waited 20 minutes, and called the local police department. The police informed DON that R1 was at the police station.			·			
	Police record dated December 14, 2016 indicated R1 showed up at the police station, which was 0.4 mile from the facility. R1 told police s/he wanted to turn him/herself in for possible affiliation with terrorist organization. The police transported R1 back to the facility.						
	Nursing progress note dated December 14, 2016 indicated after R1's was brought back to the facility, DON took away R1's coat, hat and gloves, and kept them at nursing station to prevent R1 from leaving the facility without supervision in dangerous weather.						
	Police report dated December 17, 2016 indicated a police officer and a county water patrol officer found R1 on a lake wearing jeans and a t-shirt in negative seven degree fahrenheit weather. The report indicated R1 expressed suicide ideation, suffered hypothermia, and was transported to a hospital.						
•	The DON was interviewed December 21, 2016 at 1:00 p.m. and stated that R1 eloped on December 14 and 17, 2016. The DON stated the facility did not report R1's elopement to the state agency and did not investigate how R1 eloped on December 14 and 17, 2016. The DON did not know why the facility did not report to state agency or investigate the incident. The DON stated R1 was not assessed for elopement risks. The DON stated staffs were expected to monitor and respond to door buzzer when residents leave						
Minnesota D	epartment of Health			<u> </u>			

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Minneso	ota Department of He	ealth			FURIVI	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00234	B. WING		06/1	C 1 <b>2/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE M	NNETONKA CARE C	FNTFR	MMERVILLE /EN, MN 553	•		
(XA) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 305	Continued From pa	ge 4	2 305			
	from or return to the	e facility.				
	The administrator w	vas interviewed on December				541
	21, 2016 at 1:15 p.r	m. and stated the facility did				
		pements on December 14 and gency and did not complete an				
	internal investigatio	n. Administrator also stated he		ı		
		ity was responsible for he administrator stated that				
	door buzzer was sufficient for monitoring the residents and did not want to take their freedom					
	away.	ot want to take their freedom				
	Registered nurse (F	RN)-D was interviewed on				
	December 21, 2016	6 at 4:30 p.m. and stated that				
		d to respond to door buzzer ne in or leave to go outside.				
	RN-D stated she wa	as aware of R1's elopement				
	monitor R1 due to e	016 and was told to closely elopement risk.				
	Registered nurse (F	RN)-F was interviewed on			:	
	January 9, 2017 at	3:46 p.m. and stated that				
		buzzer was difficult due to dependence with ambulation			:	
	and staff engageme	ent with care. RN-F stated that				
		f R1's December 14, 2016 tated that she was working				
	when R1 eloped on	December 17, 2016, was				
		ad hypothermia and was N-F stated she did not report				
	incident to state age					
	Facility's policy and	procedure titled Vulnerable				
		olicy dated February 2001 report and investigate				
	possible abuse or n	eglect of any resident. The			:	
		procedure did not include eening, training, prevention				
		abuse, neglect, and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIDAN	OF CONTROL	DENTIL ON THOM TO ME SERVICE	A. BUILDING:			
		00234	B. WING		06/1	, 2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE M	NNETONKA CARE CI	ENTER	MMERVILLE		4	
		DEEPHAV	'EN, MN 55		011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 305	Continued From page 5		2 305			
	exploitation of resid resident property.	lent, and misappropriation of				
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.		· .			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days.					
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560	·		
	Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).		,			
	by: Based on documen facility failed to deve comprehensive per one in four resident eloped from the fac	t review and interview, the elop and implement a son-centered care plan for s reviewed (R1) when R1 ility, had hypothermia, and was hospitalized.				
	Findings include:					
		d was reviewed. R1's schizoaffective disorder,				

6899

(X3) DATE SURVEY

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		00224	B. WING		C <b>06/12/2017</b>	
		00234	l			212011
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S <b>MMERVILLE</b>	STATE, ZIP CODE		
LAKE M	INNETONKA CARE CI	ENTER	EN, MN 553	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 6	2 560			
	bipolar disorder. R1 hospital dated Octo was admitted on Octo R1's discharge instrup with psychiatrist receiving facility.  Pre-Admission Screnursing facility place indicated that R1's redirection four or nalso indicated that I and was mentally under the properties of the propertie	d cognitive impairment, and I's discharge summary from ober 31, 2016 indicated R1 october 13, 2016 for delusions. Tructions required R1 to follow and psychologist at the ening Assessment (PAS) for ement dated October 28, 2016 behavior needed cueing and more times per week. The PAS R1 has minor forgetfulness nable for self preservation.				
	31, 2016 indicated to R1's was character	es Evaluation dated October that R1 preferred walking. ized as shy, depressed and evaluation indicated R1 was mbulation.		·		
	November 2, 2016 admissions in the p psychiatric illness. I anti-psychotic medi progress note indicamonitoring of medical	niatric progress note dated indicated R1 had 19 ast eleven months due to his R1 was started on new cation for psychosis. The ated that R1 required close cal condition and medication ation with facility staff.				
	indicated R1 wante s/he was worried at	ote dated December 14, 2016 d to leave the facility because bout the cost of living at the of nursing (DON) reassured d living there.				
	R1 showed up at th zero point four (0.4)	December 14, 2016 indicated e police station, which was mile from the facility. The R1 back to the facility.				

(X2) MULTIPLE CONSTRUCTION

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00234	B. WING		06/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE MI	NNETONKA CARE C	-N1 -R	MMERVILLE 'EN, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 560	Continued From page 7		2 560			
	indicated DON took gloves and kept the stated to prevent R unsupervised in dar Police report dated a police officer and found R1 on a lake negative seven degreport indicated R1	ote dated December 14, 2016 away R1's coat, hat and em at nursing station. DON 1 from leaving the facility ngerous weather.  December 17, 2016 indicated a county water patrol officer wearing jeans and a t-shirt in ree Fahrenheit weather. The expressed suicide ideation, ia, and was transported to a				
	p.m., director of nur not have a care pla eloped on December facility found out that on December 14, 2 the police and R1 we by the police. DON temperature was fix was dressed appro- the facility on December 12 assess or evaluated DON stated when Found at the lake or not assessed for ele- facility did not creat comprehensive care the each elopemen	re degrees Fahrenheit and R1 priately when s/he eloped from mber 14, 2016. The facility did ate R1 to prevent elopement. R1 eloped again and was a December 17, 2016, R1 was openent. DON stated the e and implement a e plan for R1 before and after t.				
	January 9, 2017 inc plan. RN-F also sta had previously elop RN-F stated that sh	licated R1 did not have a care ted she was not aware that R1 ed on December 14, 2016. e got report that R1 was a ent on December 17, 2016.				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LEIED
				·		
		00234	B. WING		06/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
IAVEM	NNETONKA CARE CI	20395 SU	MMERVILLE	ROAD		
LANE IVII	INNETONKA CARE CI	DEEPHAV	'EN, MN 55	331		
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2 560	Continued From page 8		2 560			
	not dated, indicated have a temporary completed within or plan within thirty day SUGGESTED MET The Director of Nurreview policies and	CHOD OF CORRECTION: sing or designated person to procedures, revise as d staff on revisions, and ompliance.				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as pwritten order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed provide	and document review, the eresidents with adequate				

Minnesota Department of Health

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00234	B. WING		06/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		1
LAVEMI	NNETONKA CARE C	20395 SUI	VIMERVILLE	ROAD		
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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		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 pa	ge 9	2 830			
	residents reviewed facility two times in elopment, R1 elope On second elopemery cold weather was recorded.	(R1) when R1 eloped from the three days. On the first and went to a police station. ent, R1 was found on a lake in without appropriate clothing in suffered hypothemia, and was		·		
	Findings include:					
	R1's medical record was reviewed. R1's diagnoses included schizoaffective disorder, paranoid state, mild cognitive impairment, and bipolar disorder. R1's discharge summary from hospital dated October 31, 2016 indicated R1 was admitted on October 13, 2016 for delusions. R1's discharge instructions required R1 to follow up with psychiatrist and psychologist at the receiving facility. R1's medical record did not include a temporary or comprehensive care plan to identify care areas, goals and interventions for cognitive loss, mood state, falls, nutritional status, and psychotropic drug use.					
	received a Pre-Adm (PAS), completed by facility placement do PAS indicated that loueing and redirect week. The PAS also forgetfulness and weelf from harm or do The facility's activities.	record indicated the facility hission Screening Assessment y the hospital, for nursing ated October 28, 2016. The R1's behavior needed staff's ion four or more times per o indicated that R1 had minor ras mentally unable for protect eath.  es evaluation dated October that R1 preferred walking. The				
	same evaluation inc	dicated R1 was independent 's was characterized as shy,				

PRINTED: 06/12/2017 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ C B. WING 06/12/2017 00234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 10 Review of the psychiatric progress note dated November 2, 2016 indicated R1 had 19 admissions in the past eleven months due to psychiatric illness. R1 was started on new anti-psychotic medication for psychosis. The progress note indicated that R1 required close monitoring of medical condition and medication regimen in collaboration with facility staff. Review of psychologist's assessment note dated November 5, 2016 indicated R1's had impaired memory and warned staff to watch for triggers or indication of mood changes. Nursing progress note reviewed for the week following R1's first elopement indicated R1 had escalating episodes of delusions and paranoia. R1's psychiatrist was notified on December 13. 2016 about R1's delusions and paranoia. R1 wanted to leave facility, refused to participate in outing as s/he liked in the past, thought s/he was being picked up by the Air Force, refused shower, and stated the president was kidnapped and assassinated. The progress note indicated R1 was sweating, pacing his/her room, had bag packed, and stated feeling more depressed. R1's medical record did not indicate R1's psychiatrist called back regarding R1's delusions and paranoia, but did not call the facility back. The facility did not assess R1 for adequate supervision to prevent elopement and self harm. Nursing progress note reviewed for the day

before R1's first elopement indicated DON contacted R1's case manager. R1's care manager told DON that R1 had cycles of hospitalizations every two months due to

delusions and paranoia. R1 also wanted to go to the hospital. R1 called emergency services twice, the sheriff department stating s/he wanted to turn

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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		DEEPHAV	'EN, MN 55	1	DNI .	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
2 830	Continued From pa	ge 11	2 830			
	self in, and was called and reported to sheriff department that the president has been kidnapped and assasinated.					
	indicated R1 wante s/he was worried al facility. The director R1 s/he could affor	ote dated December 14, 2016 d to leave the facility because bout the cost of living at the of nursing (DON) reassured d living there. DON stated she reakfast, but R1 wanted to go return shortly.				
	R1 showed up at th	December 14, 2016 indicated e police station, which was 0.4 y. The police transported R1				
	indicated DON took gloves and kept the prevent R1 from lea without supervision Review of nursing p 15 indicated R1 told s/he threw his/her of garbage. Activity pa December 16, 2016 decaffeinated coffee	ote dated December 14, 2016 away R1's coat, hat and am at nursing station to aving the facility in the future in dangerous weather. Orogress note dated December of facility's housekeeper that well phone battery in the articipation note dated indicated R1 thought his/her is was caffeinated, even after wed an individual cup for				·
	indicated that R1 hat to leave facility becautrouble. Staff reassinis/her room. R1 calleave the facility against the staff reassing the staff reassing the staff reason in the staff reaso	ote dated December 17, 2016 and a packed bag and wanted ause s/he was in financial ured R1 and s/he returned to ame back later and wanted to ain. Staff stated R1 went accility's mailbox, and came				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			LL 125
		00234	B. WING		06/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAVEN	NNETONKA CARE C	20395 SU	MMERVILLE	ROAD		
LAKE WI	INNETONKA CARE CI	DEEPHAV	EN, MN 553	331		·
(X4) ID PREFIX TAG			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 pa	ge 12	2 830			
	Police report dated a police officer and found R1 on a lake negative seven degreport indicated R1 suffered hypotherm hospital.	December 17, 2016 indicated a county water patrol officer wearing jeans and a t-shirt in ree Fahrenheit weather. The expressed suicide ideation, ia, and was transported to a				
	2016 indicated R1 I	record dated December 18, nad some pain, swelling and ds, blisters on right hand and lite.				
	p.m., director of nui not have a care pla eloped on December facility found out that on December 14, 2 the police and R1 we by the police. DON temperature was fix was dressed appro- the facility on December 1 elo 2016 and was found assessed or evaluar als stated that R1 de his/her care at the faware of R1's past two due to his/her passes	re degrees Fahrenheit and R1 priately when s/he eloped from mber 14, 2016. The facility did ate R1's elopement risk. DON ped again on December 17, d at the lake, R1 was not ted for elopement risks. DON id not have care plan to guide acility. DON stated she was cycles of hospitalization every sychiatric illness.				
	(RN)-F stated that r difficult due to most with ambulation and RN-F also stated sh previously eloped o	anuary 9, 2017 at 3:46 p.m., responding to door buzzer was residents's independence d staff engagement with care. The was not aware that R1 had n December 14, 2016. RN-F to got report that R1 was a high				

FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED. IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ CB. WING 06/12/2017 00234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 8 3 0 Continued From page 13 risk of elopement on December 17, 2016. The facility policy and procedure titled Community Assessment and Safety dated August 2012 indicated a physician's order will be obtained to indicate whether or not a resident is allowed to walk off the ground. The policy also indicated the facility will determine the extent to which each resident is appropriately safe to venture into the community. Facility's policy and procedure titled Decompensated Resident Management dated June 1991 indicated each staff member is to prevent an acting-out resident from injuring him/herself or others. Facility's policy and procedure titled Incident/Accident Reporting dated November 1991 indicated the facility should report and document any incident or accident involving a resident. The policy did indicate how soon the report must be completed. Facility's policy and procedure titled Leave of Absence policy dated July 2016 indicated that facility's staff must ensure residents sign out and sign in the date and time when they returned and left the facility. Facility's policy and procedure titled Vulnerable Adults Protection Policy dated February 2001 indicated that must report and investigate possible abuse or neglect of any resident. The facility's policy and procedure did not include

resident property.

components for screening, training, prevention and identification of abuse, neglect, and

exploitation of resident, and misappropriation of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:		OOWN LETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
1 41/17 88	NNETONIKA CADE CI	20395 SU	MMERVILLE	ROAD		
LAKE WI	NNETONKA CARE C	DEEPHAV	'EN, MN 553	331		
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2 830	Continued From pa	ge 14	2 830			
	The Director of Nur review policies and	R CORRECTION:				
21850	Residents of HC Fa Subd. 14. Freedon Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, sintentional and non- physical pain or inju- conduct intended to distress. Every resident shere and except in fully docu- authorized in writing resident's physician period of time, and	c. Bill of Rights om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the etherapeutic infliction of ary, or any persistent course of a produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as a after examination by a for a specified and limited only when necessary to	21850			
	by: Based on interview facility failed to ensimaltreatment for or (R1) when R1 elope three days. On the went to a police start was found on a	and document review, the ure resident is free from the in four residents reviewed and from the facility two times in first elopment, R1 eloped and tion. On second elopement, lake in very cold weather clothing in a suicide attempt,				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
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00234		00234	B. WING		06/12/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKE M	NNETONKA CARE CI	ENTER	MMERVILLE			
	S.W.W. D./ 074		'EN, MN 55		ON OVE	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
21850	Continued From pa	ge 15	21850			
	suffered hypothemi	a, and was hospitalized.				
	Findings include:					
	diagnoses included paranoid state, mild bipolar disorder. R1 hospital dated Octowas admitted on Octowas admitted on Octowas admitted instruption with psychiatrist receiving facility. R2 include a temporary to identify care area	d was reviewed. R1's schizoaffective disorder, decognitive impairment, and l's discharge summary from ober 31, 2016 indicated R1 etober 13, 2016 for delusions. Tructions required R1 to follow and psychologist at the 1's medical record did not year or comprehensive care plantas, goals and interventions for distate, falls, nutritional status, rug use.				
	received a Pre-Adm (PAS), completed b facility placement d PAS indicated that cueing and redirect week. The PAS also	record indicated the facility nission Screening Assessment by the hospital, for nursing ated October 28, 2016. The R1's behavior needed staff's ion four or more times per o indicated that R1 had minor was mentally unable for protect eath.				
	31, 2016 indicated same evaluation inc	es evaluation dated October that R1 preferred walking. The dicated R1 was independent I's was characterized as shy, ious.	·			
·	November 2, 2016 admissions in the p psychiatric illness. I anti-psychotic medi	niatric progress note dated indicated R1 had 19 ast eleven months due to R1 was started on new cation for psychosis. The ated that R1 required close				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00234	B. WING		1	C <b>06/12/2017</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LAKE M	NNETONKA CARE CI	-NIFR	MMERVILLE /EN, MN 553				
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
21850	monitoring of medic regimen in collaborate Review of psycholo November 5, 2016 memory and warne indication of mood of Nursing progress not following R1's first descalating episodes R1's psychiatrist was 2016 about R1's dewanted to leave factouting as s/he liked being picked up by and stated the pressussassinated. The pwas sweating, pacing packed, and stated medical record did called back regarding paranoia, but did not facility did not assessing progress not before R1's first elocontacted R1's case manager told DON hospitalizations ever delusions and paranthe hospital. R1 call the sheriff department self in, and was call department that the	cal condition and medication ation with facility staff.  gist's assessment note dated indicated R1's had impaired d staff to watch for triggers or changes.  Other reviewed for the week elopement indicated R1 had a of delusions and paranoia. It is notified on December 13, lusions and paranoia. R1 ility, refused to participate in in the past, thought s/he was the Air Force, refused shower, ident was kidnapped and progress note indicated R1 and his/her room, had bag feeling more depressed. R1's not indicate R1's psychiatrist and R1's delusions and of call the facility back. The se R1 for adequate ent elopement and self harm.  Other reviewed for the day perment indicated DON enter the manager. R1's care that R1 had cycles of ry two months due to noia. R1 also wanted to go to led emergency services twice, ent stating s/he wanted to turn ed and reported to sheriff president has been	21850				
		ote dated December 14, 2016 d to leave the facility because					

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 06/12/2017 00234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER **DEEPHAVEN, MN 55331** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 17 21850 s/he was worried about the cost of living at the

facility. The director of nursing (DON) reassured R1 s/he could afford living there. DON stated she asked R1 to have breakfast, but R1 wanted to go outside and would return shortly. Police record dated December 14, 2016 indicated R1 showed up at the police station, which was 0.4

mile from the facility. The police transported R1 back to the facility. Nursing progress note dated December 14, 2016 indicated DON took away R1's coat, hat and gloves and kept them at nursing station to prevent R1 from leaving the facility in the future

without supervision in dangerous weather. Review of nursing progress note dated December 15 indicated R1 told facility's housekeeper that s/he threw his/her cell phone battery in the garbage. Activity participation note dated December 16, 2016 indicated R1 thought his/her decaffeinated coffee was caffeinated, even after the coffee shop brewed an individual cup for him/her.

Nursing progress note dated December 17, 2016 indicated that R1 had a packed bag and wanted to leave facility because s/he was in financial trouble. Staff reassured R1 and s/he returned to his/her room. R1 came back later and wanted to leave the facility again. Staff stated R1 went outside, walked to facility's mailbox, and came back inside.

Police report dated December 17, 2016 indicated a police officer and a county water patrol officer found R1 on a lake wearing jeans and a t-shirt in negative seven degree Fahrenheit weather. The report indicated R1 expressed suicide ideation, suffered hypothermia, and was transported to a

PRINTED: 06/12/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 06/12/2017 00234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21850 Continued From page 18 21850 hospital. Review of hospital record dated December 18, 2016 indicated R1 had some pain, swelling and tingling of both hands, blisters on right hand and left wrist, and frostbite. In an interview on December 21, 2016 at 12:00 p.m., director of nursing (DON) stated that R1 did not have a care plan. The DON stated that R1 eloped on December 14, 2016. DON stated facility found out that R1 eloped from the property on December 14, 2016. DON stated she called the police and R1 was brought back to the facility by the police. DON stated the outdoor temperature was five degrees Fahrenheit and R1 was dressed appropriately when s/he eloped from the facility on December 14, 2016. The facility did not assess or evaluate R1's elopement risk. DON stated when R1 eloped again on December 17, 2016 and was found at the lake, R1 was not assessed or evaluated for elopement risks. DON als stated that R1 did not have care plan to guide his/her care at the facility. DON stated she was aware of R1's past cycles of hospitalization every two due to his/her psychiatric illness. In interview dated January 9, 2017 at 3:46 p.m., (RN)-F stated that responding to door buzzer was difficult due to most residents's independence with ambulation and staff engagement with care. RN-F also stated she was not aware that R1 had

Minnesota Department of Health

previously eloped on December 14, 2016. RN-F also stated that she got report that R1 was a high

The facility policy and procedure titled Community Assessment and Safety dated August 2012 indicated a physician's order will be obtained to indicate whether or not a resident is allowed to

risk of elopement on December 17, 2016.

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	,	
LAKE MI	NNETONKA CARE CI	INTED	MMERVILLE 'EN, MN 553			
(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
21850	Continued From pa	ge 19	21850			
	walk off the ground. The policy also indicated the facility will determine the extent to which each resident is appropriately safe to venture into the community.					
	June 1991 indicated	esident Management dated d each staff member is to ut resident from injuring				
	Adults Protection Pointicated that must possible abuse or n facility's policy and components for scr and identification of	procedure titled Vulnerable blicy dated February 2001 report and investigate eglect of any resident. The procedure did not include eening, training, prevention abuse, neglect, and ent, and misappropriation of				
	The Director of Nurreview policies and	HOD OF CORRECTION: sing or designated person to procedures, revise as d staff on revisions, and ompliance.				
	TIME PERIOD FOR Twenty-One (21) da					
21980	MN St. Statute 626. Maltreatment of Vul	557 Subd. 3 Reporting - nerable Adults	21980			
	reporter who has re vulnerable adult is to or who has knowled has sustained a phy	f report. (a) A mandated ason to believe that a being or has been maltreated, lige that a vulnerable adult visical injury which is not ad shall immediately report the				

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED. AND PLAN OF CORRECTION A. BUILDING: \_ B. WING 06/12/2017 00234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) 21980 21980 Continued From page 20 information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section

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626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_\_\_ C B. WING 00234 06/12/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21980 21980 Continued From page 21 information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced Based on preponderance of evidence, the facility failed to investigate and report an alleged violation of neglect for one of four residents (R1) reviewed when it did not immediately report and investigateR1's elopement, hypothermia, suicide attempt and hospitalization. Findings include: R1's medical record was reviewed. R1 has diagnoses of schizoaffective disorder, paranoid state, mild cognitive impairment, and bipolar disorder. Discharge Summary from hospitatilization dated October 31, 2016 indicated R1 was admitted October 13, 2016 for delusions. R1's discharge orders stated R1 is to stay in touch with psychiatrist and not wait for symptoms of depressions (increased confusion, mood getting worse and/or suicidal thoughts) to get worse before seeking help. R1's discharge instructions also required R1 to follow up with psychiatrist and psychologist at the receiving facility. Review of State of Minnesota's cour document dated June 1, 2016 indicated that R1 had an Order for Recommitment as Mentally III until June 10, 2017. The court record also indicated that R1 had an order authorizing use of neuroleptic medication.

Pre-Admission Screening Assessment (PAS) for nursing facility placement dated October 28, 2016 indicated that R1's behavior needed staff's cueing

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2016 indicated provider orders/communication to nurse for prescription of Zyprexa 5mg by mouth daily as needed for psychosis/agitation. The form also indicated staff to update the provider in one

Psychologist's diagnostic assessment note dated November 5, 2016 indicated R1's memory is impaired. The noted indicated R1 reported sleep, eating, and motivation issues. Psychologist's

week with follow up in one month.

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Nursing progress note dated December 12, 2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ С B. WING 00234 06/12/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 20395 SUMMERVILLE ROAD LAKE MINNETONKA CARE CENTER DEEPHAVEN, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21980 21980 Continued From page 24 indicated R1 was leaving via cab to meet someone at the airport and would be back later. Nursing progress note dated December 13, 2016 indicated R1 called emergency medical services (911) twiceduring the shift. The note indicated the psychiatrist was notified about R1's increased delusions and medication (Zyprexa) not effective for R1's behaviors. Nursing progress note dated December 14, 2016 indicated Hennepin County Sheriff Department called the DON and reported that R1 had called the department to report the president has been kidnapped and assassinated. DON reported R1 told her about feeling more depressed and was pacing back and forth. The note also indicated DON notified R1's psychiatrist of R1's delusions. DON noted that she gave R1 a dose of Zyprexa 5mg, but R1 continued to request discharge to a psychiatric hospital. Nursing progress note dated December 14, 2016 indicated R1 wanted to leave facility because of cost. The note indicated that DON reminded R1 that the temperature was five degrees outside Fahrenheit but allowed R1 to leave and R1 was brought back by the Deephaven Police Department. Nursing progress note dated December 14, 2016 indicated DON took away R1's coat, hat and gloves and kept them at nursing station to prevent R1 from leaving the facility unsupervised in dangerous weather.

Nursing progress note dated December 14, 2016 indicated R1 told DON that he could not receives disability benefits to pay for stay at the facility.

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NAME OF PROVIDER OR SUPPLIER		STREET ADD	STREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE MINNETONKA CARE CENTER 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
21980	Continued From page 25  Activity participation note dated Dece 2016 indicated R1 was agitated and a because R1 reported coffee was caffi when it was not.  Behavior/Intervention Monthly Flow R December 2016 indicated R1 had dethoughts and agitation/psychosis duri evening shifts on December 12, 13, 1  Leave of Absence record dated Deceindicated that R1 left without signing i December 2, 4 and twice on Decemb Nursing progress note dated Decembindicated R1 attempted to leave facilitifinancial troubles, but was redirected note also indicated R1 came back to around 1:30 p.m., and asked to go ouwas allowed to stay outside for five mhe returned.  Deephaven Police record dated Dece 2016 indicated R1 showed up at the pstation, which is zero point four (0.4) in the care facility. The report indicated called and was told officer was bringing to the facility.  Deephaven Police Department report December 17, 2016 indicated their of Hennepin County Water Patrol found lake wearing jeans and a t-shirt in neg degree Fahrenheit weather. The report 1 expressed suicide ideation, suffer hypothermia and was transported to a linterview with resgistered nurse (RN) December 21, 2016 at 4:30 p.m. indicatef is expected to respond to door by	enxious einated  decord dated lusional ng day and 14, and 16.  mber 2016 in on er 11.  per 17, 2016 ty due to to stay. The nurse, utside. R1 inutes and  ember 14, police mile from the DON ng R1 back  dated ficer and R1 on a gative seven int indicated ed a hospital.  D dated cated that	21980					

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not complete incident reports and did not have written internal investigation for both incidents.

Interview with registered nurse (RN)-F dated January 9, 2017 indicated that responding to door buzzer can be difficult due to most residents's independence with ambulation and staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED					
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
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21980	engagement with canot aware that R1 h December 14, 2016 got report that R1 won December 17, 20 The facility policy arnot dated, indicated have a temporary canopleted within or plan within thirty day. The facility policy ar Assessment and Saindicated that a physic indicate whether walk off the ground. facility will determine resident is appropria community. R1 did is safety assessment. The facility policy ard Decompensated Redune 1991 indicated prevent an acting-out him/herself or others. Facility's policy and Incident/Accident Reduced the facility's policy and Incident any incideresident. The policy report must be compensated policy date.	are. RN-F also stated she was ad previously eloped on 6. RN-F also stated that she was a high risk of elopement 016.  Ind procedure titled Care Plan, of that each resident must are plan assessment are week and a permanent care we was an apermanent care was upon admission.  Ind procedure titled Community afety dated August 2012 sician's order will be obtained for not a resident is allowed to a the extent to which each ately safe to venture into the mot have community and done.  Ind procedure titled each staff member is to but resident from injuring second or accident involving a did indicate how soon the	21980	DETICIENCY						
		esident leaves the facility.								

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