MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Lake Minnetonka Care Center

Facility Address:
20395 Summerville Road

Facility City:
Deephaven

State: Minnesota | **ZIP:** 55331 | **County:** Hennepin

Report Number:
H5606007

Date of Visit:
December 21 and 22, 2016

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

Investigator's Name and Title:
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)
- ☒ 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.

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

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

The facility did not assess, monitor, and supervise the resident for safety based on its Community Assessment/Safety and Vulnerable Adult Abuse Prevention policies.

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.

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

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:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] 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 ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Hospitalized

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ○ Yes ○ No ◉ N/A Specify: Estranged from family

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Hospitalized

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ 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): ○ Yes ○ 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 ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour
☒ Injury

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A
Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

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

DEPARTMENT OF HEALTH

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.

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 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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	R-C 08/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on August 22, 2017, to follow up on deficiencies issued relate to complaint H5606007. Lake Minnetonka Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5606007. As a result, the following deficiencies are issued.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	F 225		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to immediately report to state agency and investigate an alleged violation of neglect for one of four residents, (R1) reviewed, when R1 eloped from the facility on two occasions. On the first elopement, R1 was found at a police station. On the second elopement, R1 was found on a lake in an attempted suicide, had hypothermia,	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 and was hospitalized. 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. Discharge instructions to the facility required R1 to follow up with psychiatrist and psychologist. Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death. Nursing progress note dated December 14, 2016 indicated R1 wanted to leave because 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. R1 insisted that s/he wanted to walk on facility's grounds. The DON agreed and told R1 to stay on facility's grounds. The DON told R1 that the outdoor temperature 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	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 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 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	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 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 found at the lake, had hypothermia and was taken to hospital. RN-F stated she did not report incident to state agency. 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 components for screening, training, prevention and identification of abuse, neglect, and exploitation of resident, and misappropriation of resident property.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 5 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and implement policies and procedures to report and investigate an allleged violation of neglect for one of four residents, (R1) reviewed, when R1 elopeed from	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6 the facility on two occasions. On the first elopement, R1 was found at a police station. On the second elopement, R1 was found on a lake in an attempted suicide, had hypothermia, and was hospitalized. Findings include: 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 components for screening, training, prevention and identification of abuse, neglect, and exploitation of resident, and misappropriation of resident property. 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. Discharge instructions to the facility required R1 to follow up with psychiatrist and psychologist. Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death. Nursing progress note dated December 14, 2016 indicated R1 wanted to leave because s/he was	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 worried about the cost of living at the facility. The director of nursing (DON) reassured R1 s/he could afford living there. R1 insisted that s/he wanted to walk on facility's grounds. The DON agreed and told R1 to stay on facility's grounds. DON stated she told R1 that the outdoor temperature was five degrees Fahrenheit and R1 was dressed appropriately. R1 went outside and eloped the facility from the facility grounds. When 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 self 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. Director of Nursing (DON) was interviewed December 21, 2016 at 1:00 p.m. and stated that R1 eloped on December 14 and 17, 2016. The	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	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 found at the lake, had hypothermia and was taken to hospital. RN-F stated she did not report	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 incident to state agency.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for one in four residents reviewed (R1) when R1 eloped twice from the facility. On the first occasion, R1 eloped and was found at a police station. On the second elopement, R1 was found on a lake in a suicide attempt, had hypothermia, and was hospitalized. Findings include: R1's medical record was reviewed. R1's diagnoses included schizoaffective disorder,	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11	F 279		

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 of cognitive loss, mood state, falls, nutritional status, and psychotropic drug use. R1's medical record did not identify goals and interventions for these care areas.

Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death.

The facility's activities evaluation dated October 31, 2016 indicated that R1 preferred walking. The same evaluation indicated R1 was independent with ambulation. R1's was characterized as shy, depressed and anxious.

Review of the psychiatric progress note dated November 2, 2016 indicated R1 had 19 admissions in the past eleven months due to his psychiatric illness. R1 was started on new anti-psychotic medication for psychosis. The progress note indicated R1 required facility staff's close monitoring of medical condition and medication regimen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 12 Nursing progress note dated December 14, 2016 indicated R1 wanted to leave the facility because 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. Police record dated December 14, 2016 indicated R1 showed up at the police station, which was zero point four (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. DON stated to prevent R1 from leaving the facility unsupervised 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. 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 developed. The DON stated that R1 eloped 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 R1 eloped from the facility on December 14, 2016. The facility did not assess or evaluate R1 to prevent elopement. DON stated when R1 eloped again on December 17, 2016, and was found at the lake. Facility did not assess R1 for elopement	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13 risks. DON stated the facility did not develop and implement a comprehensive care plan for R1 before and after the each elopement. Interview with registered nurse (RN)-F dated January 9, 2017 indicated R1 did not have a care plan. RN-F also stated she was not aware that R1 had previously eloped on December 14, 2016. RN-F stated that she got report that R1 was a high risk of elopement on December 17, 2016. The facility policy and procedure titled Care Plan, not dated, indicated that each resident must have a temporary care plan assessment completed within one week and a permanent care plan within thirty days upon admission.	F 279		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed provide residents with adequate supervision to prevent elopement for one in four residents reviewed (R1) when R1 eloped from the facility two times in three days. On the first elopment, R1 eloped and went to a police station. On second elopement, R1 was found on a lake in very cold weather without appropriate clothing in a suicide attempt, suffered hypothemia, and was hospitalized. 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. Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death. The facility's activities evaluation dated October 31, 2016 indicated that R1 preferred walking. The same evaluation indicated R1 was independent with ambulation. R1's was characterized as shy, depressed and anxious. 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 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 self in, and was called and reported to sheriff department that the president has been kidnapped and assasinated. . Nursing progress note dated December 14, 2016 indicated R1 wanted to leave the facility because 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 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 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., the 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 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 previously eloped on December 14, 2016. RN-F also stated that she got report that R1 was a high 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.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 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 components for screening, training, prevention and identification of abuse, neglect, and exploitation of resident, and misappropriation of resident property.	F 323		

DEPARTMENT OF HEALTH

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	R-C 08/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5606007. Lake Minnetonka was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	R-C 08/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 page of the State form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5606007. As a result, the following correction orders are issued.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 305	MN Rule 4658.0110 Incident and Accident Reporting All persons providing services in a nursing home must report any accident or injury to a resident, and the nursing home must immediately complete a detailed incident report of the accident or injury and the action taken after learning of the accident or injury. This MN Requirement is not met as evidenced	2 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 305	Continued From page 2 by: Based on document review and interview, the facility failed to immediately report to state agency and investigate an alleged violation of neglect for one of four residents, (R1) reviewed, when R1 eloped from the facility on two occasions. On the first elopement, R1 was found at a police station. On the second elopement, R1 was found on a lake in an attempted suicide, had hypothermia, and was hospitalized. 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. Discharge instructions to the facility required R1 to follow up with psychiatrist and psychologist. Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death. Nursing progress note dated December 14, 2016 indicated R1 wanted to leave because 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. R1 insisted that s/he wanted to walk on facility's grounds. The DON agreed and told R1 to stay on facility's grounds. The DON told R1 that the outdoor temperature	2 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 305	Continued From page 3 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	2 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 305	Continued From page 4 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 found at the lake, had hypothermia and was taken to hospital. RN-F stated she did not report incident to state agency. 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 components for screening, training, prevention and identification of abuse, neglect, and	2 305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 305	Continued From page 5 exploitation of resident, and misappropriation of resident property. 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.	2 305		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents 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). This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for one in four residents reviewed (R1) when R1 eloped from the facility, had hypothermia, attempted suicide, and was hospitalized. Findings include: R1's medical record was reviewed. R1's diagnoses included schizoaffective disorder,	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 6 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. Pre-Admission Screening Assessment (PAS) for nursing facility placement dated October 28, 2016 indicated that R1's behavior needed cueing and redirection four or more times per week. The PAS also indicated that R1 has minor forgetfulness and was mentally unable for self preservation. The facility's Activities Evaluation dated October 31, 2016 indicated that R1 preferred walking. R1's was characterized as shy, depressed and anxious. The same evaluation indicated R1 was independent with ambulation. Review of the psychiatric progress note dated November 2, 2016 indicated R1 had 19 admissions in the past eleven months due to his 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. Nursing progress note dated December 14, 2016 indicated R1 wanted to leave the facility because 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. Police record dated December 14, 2016 indicated R1 showed up at the police station, which was zero point four (0.4) mile from the facility. The police transported R1 back to the facility.	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 7 Nursing progress note dated December 14, 2016 indicated DON took away R1's coat, hat and gloves and kept them at nursing station. DON stated to prevent R1 from leaving the facility unsupervised 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. 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 to prevent elopement. DON stated when R1 eloped again and was found at the lake on December 17, 2016, R1 was not assessed for elopement. DON stated the facility did not create and implement a comprehensive care plan for R1 before and after the each elopement. Interview with registered nurse (RN)-F dated January 9, 2017 indicated R1 did not have a care plan. RN-F also stated she was not aware that R1 had previously eloped on December 14, 2016. RN-F stated that she got report that R1 was a high risk of elopement on December 17, 2016.	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 8 The facility policy and procedure titled Care Plan, not dated, indicated that each resident must have a temporary care plan assessment completed within one week and a permanent care plan within thirty days upon admission. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed provide residents with adequate supervision to prevent elopement for one in four	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 residents reviewed (R1) when R1 eloped from the facility two times in three days. On the first elopment, R1 eloped and went to a police station. On second elopement, R1 was found on a lake in very cold weather without appropriate clothing in a suicide attempt, suffered hypothemia, and was hospitalized. 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. Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death. The facility's activities evaluation dated October 31, 2016 indicated that R1 preferred walking. The same evaluation indicated R1 was independent with ambulation. R1's was characterized as shy, depressed and anxious.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	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	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 self in, and was called and reported to sheriff department that the president has been kidnapped and assasinated. . Nursing progress note dated December 14, 2016 indicated R1 wanted to leave the facility because 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.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 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. 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 previously eloped on December 14, 2016. RN-F also stated that she got report that R1 was a high	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	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 components for screening, training, prevention and identification of abuse, neglect, and exploitation of resident, and misappropriation of resident property.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 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.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident is free from maltreatment for one in four residents reviewed (R1) when R1 eloped from the facility two times in three days. On the first elopment, R1 eloped and went to a police station. On second elopement, R1 was found on a lake in very cold weather without appropriate clothing in a suicide attempt,	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 15 suffered hypothemia, and was hospitalized. 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. Review of facility's record indicated the facility received a Pre-Admission Screening Assessment (PAS), completed by the hospital, for nursing facility placement dated October 28, 2016. The PAS indicated that R1's behavior needed staff's cueing and redirection four or more times per week. The PAS also indicated that R1 had minor forgetfulness and was mentally unable for protect self from harm or death. The facility's activities evaluation dated October 31, 2016 indicated that R1 preferred walking. The same evaluation indicated R1 was independent with ambulation. R1's was characterized as shy, depressed and anxious. 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	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 16 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 self in, and was called and reported to sheriff department that the president has been kidnapped and assasinated. . Nursing progress note dated December 14, 2016 indicated R1 wanted to leave the facility because	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 17 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	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 18 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 previously eloped on December 14, 2016. RN-F also stated that she got report that R1 was a high 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	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 19 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 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 components for screening, training, prevention and identification of abuse, neglect, and exploitation of resident, and misappropriation of resident property. 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.	21850		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 by: 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 Ill 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	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 22 and redirection four or more times per week. The PAS also indicated that R1 has minor forgetfulness and was mentally unable for self preservation. Facility's Activaties Evaluation dated October 31, 2016 indicated that R1 preferred walking. The Activities Evaluation also indicated R1's short- and long-term memory as normal and decision-making as modified independence. R1's is characterized as shy, depressed and anxious. The same evaluation indicated R1 is independent with ambulation. Facility's Leave of Absence record dated October 2016 indicated that R3 did not sign in on October 5, 6, 7, 11, 12, 13, and 14. Review of psychiatrist's progress note dated November 2, 2016 indicated R1 had nineteen admissions in the past eleven months due to his psychiatric illness. The progress note also indicated that R1 was started on new medication, Zyprexa 5 mg, once daily as needed for psychosis. The progress note indicated that R1 required close monitoring of medical condition and medication regimen in collaboration with facility staff. Physician Rounding Form dated November 2, 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 week with follow up in one month. 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	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 23 noted indicated the importance to watch for triggers or indication of mood changes and to follow up in a month. Facility's Leave of Absence record dated November 2016 indicated that R1 did not sign in on November 23 and 24. The record showed that R3 did not sign in on November 28 and 29. Nursing progress note dated December 9, 2016 indicated R1 was withdrawn, told nurse that about not feeling well and nurse encouraged R1 to talk if needed. Psychologist's progress note dated December 10, 2016 indicated that nursing care team reported R1 has more feeling of depression. The progress note indicated R1's increase in depressive symptoms necessitates some psychotropic medication evaluation. Nursing progress note dated December 11, 2016 indicated R1 reported that R1 stated he/she was going to the courthouse but was redirected by staff to stay. Nursing progress note dated December 12, 2016 at 10:28 a.m. indicated R1 was seen walking to the front door with coat open, gloves in hand, and outside temperature was negative eight degree Fahrenheit. Nursing progress note dated December 12, 2016 indicated R1 reported to Director of Nursing (DON) that R1 was being picked up by the Air Force for a capital crime. The note indicated that DON gave R1 a dose of Zyprexa 5mg for his delusion. Nursing progress note dated December 12, 2016	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 25 Activity participation note dated December 16, 2016 indicated R1 was agitated and anxious because R1 reported coffee was caffeinated when it was not. Behavior/Intervention Monthly Flow Record dated December 2016 indicated R1 had delusional thoughts and agitation/psychosis during day and evening shifts on December 12, 13, 14, and 16. Leave of Absence record dated December 2016 indicated that R1 left without signing in on December 2, 4 and twice on December 11. Nursing progress note dated December 17, 2016 indicated R1 attempted to leave facility due to financial troubles, but was redirected to stay. The note also indicated R1 came back to nurse, around 1:30 p.m., and asked to go outside. R1 was allowed to stay outside for five minutes and he returned. Deephaven Police record dated December 14, 2016 indicated R1 showed up at the police station, which is zero point four (0.4) mile from the care facility. The report indicated the DON called and was told officer was bringing R1 back to the facility. Deephaven Police Department report dated December 17, 2016 indicated their officer and Hennepin County Water Patrol 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. Interview with resgistered nurse (RN)-D dated December 21, 2016 at 4:30 p.m. indicated that staff is expected to respond to door buzzer when	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 26 resident comes in or leaves 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. Interview with DON dated December 21, 2016 at 1:00 p.m. indicated that R1 did not have a care plan. The DON stated that R1 eloped on December 14, 2016. DON stated facility has no documentation of re-reassessment of R1, incident report, or report to state agency. DON stated when R1 was found at the lake, nurse did not complete incident report and did not report incident to state agency. DON confirmed that R1 did not have community safety assessment completed. DON also stated that R1 did not have immediate or comprehensive care plan to address R1's safety and supervision. DON indicated that R3 has history of elopement in the past. DON acknowledged that staffs were expected to monitor and respond to door buzzer when R1 leaves or returns. Interview with administrator dated December 21, 2016 indicated the facility used door buzzer to monitor resident leaving and returning to the facility. Administrator also stated that some of facility's residents need closer monitoring. The administrator also stated staff are expected to respond to door alarm to ensure residents are monitored closely. Administrator stated that facility did not report R1's elopements on December 14 and 17, 2016 to state agency, did 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	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 27 engagement with care. RN-F also stated she was not aware that R1 had previously eloped on December 14, 2016. RN-F also stated that she got report that R1 was a high risk of elopement on December 17, 2016. The facility policy and procedure titled Care Plan, not dated, indicated that each resident must have a temporary care plan assessment completed within one week and a permanent care plan within thirty days upon admission. The facility policy and procedure titled Community Assessment and Safety dated August 2012 indicated that 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. R1 did not have community and safety assessment done. The facility 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 will make sure the date and time are completed when a resident leaves the facility.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	C 06/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 28 Facility's policy and procedure titled Vulnerable Adults Protection Policy dated February 2001 indicated that the Office of Health Facility Complaints should be notified of possible abuse or neglect of any resident. 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.	21980		