DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0PEL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/12/2006**

6. DATE OF SURVEY 3/24/14 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective March 19, 2014, the facility is certified for 116 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 04/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Certification Specialist 04/29/14 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/03/2014 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5184 April 29, 2014

Mr. Shane Roche, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Dear Mr. Roche:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 19, 2014 the above facility is certified for:

116 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 116 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 6, 2014

Mr. Shane Roche, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

RE: Project Number S5184026 and H5184077

Dear Mr. Roche:

On March 7, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 7, 2014 that included an investigation of complaint number H5184077 that was found to be substantiated. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 24, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 19, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 7, 2014, effective March 19, 2014 and therefore remedies outlined in our letter to you dated March 7, 2014, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program,Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245184	A. Building B. Wing	3/24/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0254** Reg. # **483.15(h)(3)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0258** Reg. # **483.15(h)(7)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **03/19/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **03/19/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/19/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/19/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/19/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/19/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	04/02/2014	10160	03/24/2014
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/7/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245184	A. Building B. Wing 01 - MAIN BUILDING 01	3/19/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	03/07/2014	ID Prefix Reg. # NFPA 101 LSC K0050	03/07/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KFD	04/02/2014	25822	3/19/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/5/2014	

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0PEL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/12/2006**

6. DATE OF SURVEY **02/07/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Lageson, HFE NE II 3/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 4/3/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5184

At the time of the Standard surveyon February 7, 2014 the facility was not in substantial compliance with Federal Certification Regulations. In addition, at the time of the standard survey the Minnesota Department of Health completed an investigation of complaint number H5184074 that was substantiated and complaint number H5184077 that was found to be unsubstantiated.This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8538

March 6, 2014

Mr. Shane Roche, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

RE: Project Number S5184026, H184074 and 5184077

Dear Mr. Roche:

On February 7, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 7, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5184074. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 7, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5184077 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 19, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 7, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 7, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

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
	245184	A. BUILDING _____ B. WING _____	02/07/2014

MAR 14 2014
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation/s had been completed at the time of the standard recertification survey. Investigation/s of complaint H184074 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F254. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5184077 had not been substantiated during this survey.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide adequate supply of bath linens to provide morning cares to residents on 3 west.	F 254	3/14/14 GPM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 3-12-14

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

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	245184	A. BUILDING _____ B. WING _____ MAR 14 2014 MN Dept of Health Rochester	02/07/2014

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F 254	Continued From page 1 This affects all 17 residents which included resident (R)-133 who needed towels for grooming. Findings include: R133 was observed during morning cares on 2/6/14 at 7:35 a.m. R133 had been observed to be washed and dried using two wash cloths. Nursing assistant (NA)-A stated the third floor did not have cloth towels available so they used wash cloths in place of the towel. NA-B who was helping NA-A at the time said she could not find a hand towel for R133. The linen closet was checked and observed on 3rd floor west at 8:08 a.m. and contained 1 bath towel, no hand towels, and 3 wash clothes. On 2/6/14 at 8:12 a.m. social worker (SW)-Z was observed to bring a plastic bag containing 4 bath towel and hand towels to the unit. On 2/5/14 at 1:30 p.m. laundry aid (LA)-A stated the nursing units do run out of linens sometimes. On 2/6/14 at 9:20 a.m. licensed practical nurse/case manager of third floor west stated she was unaware of the lack of linen this morning for resident use. She continued to say that this has happened on other occasions and that a staff member should have called down to laundry to get more delivered. On 2/6/14 at 9:30 a.m. the laundry director (LD) was interviewed and he indicated laundry staff arrive at 4:30 a.m. and do the laundry from the day before. LD continues to say that the laundry is taken to the floors between 9:00 a.m. and 9:30	F 254	The facility will provide and have available clean linens for the 17 residents affected and including Resident R133. The facility will provide and have available clean/adequate linen for all residents All nursing staff have been educated on the process of ensuring linens are available. Inservices were completed on February 19 and 20, 2014. Inservices were completed by the DNS and DCE. All environmental services staff have been inserviced by the Environmental Services Manager on proper linen quantities and stocking needs. Weekly audits will be conducted once a week x 4 weeks and then once a month x 3 months and as needed to monitor compliance of adequate linens. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. Executive Director is the responsible party Corrective Action will be completed by March 19th, 2014	3-19-14

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F 254	Continued From page 2 a.m. LD indicated the facility had extra linen which was locked in the storage area. On 2/6/14 at 2:50 p.m. the director of nursing stated she was not aware there had been a lack of linens for resident and staff use on the third floor east unit questioned staff concerning this issue.	F 254		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain comfortable sound levels for 2 of 12 residents (R58, R117) interviewed on 2nd floor. Findings include: R58 had complaints of facility noise loud enough to wake them during the night. R58 was interviewed on 2/05/14, at 9:34 a.m., and stated the facility gets noisy about 4:00 a.m., even with the room door closed. During interview on 2/6/14, at 11:30 a.m., R58 stated the hallway was noisy at night with rolling carts and squeaky shoes worn by staff. R117 had complaints of facility noise that woke them from sleep without facility intervention. R117 was interviewed on 2/4/14, at 2:45 p.m., and stated the facility vacuumed the hallway	F 258	The facility will provide for the maintenance of comfortable sound levels for the two residents affected by changing the vacuuming schedules to a later time in the morning. All wheels on carts will be evaluated for opportunities reduce noise levels. This evaluation will be completed by March 4, 2014. All residents have the potential to be affected. The facility will provide for the maintenance of comfortable noise levels for all residents by changing the vacuuming schedules to a later time in the morning. This was completed on February 28, 2014. All staff will be in serviced on the importance of maintaining noise levels. Housekeeping staff will be in serviced on maintaining noise levels. Education was completed through inservice meetings held on February 19 and 20. The education was completed by the DCE and DNS.	3-19-14

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F 258	Continued From page 3 floors at 7:00 a.m., with room door open and wakes everyone up. R117 stated had reported the vacuum noise to staff and was told they could not change the schedule. R117 said maybe they vacuum early to wake everyone up for the day. During observations on 2/6/14, at 6:54 a.m., housekeeper (H)-A was observed vacuuming the length of the hallway that included R117 ' s room. During interview at that time, H-A stated they had been aware a resident had complained about early vacuum noise but was instructed to vacuum at 7:00 a.m. During interview on 2/6/14, at 11:30 a.m., housekeeping manager stated facility had always run the vacuum at 7:00 a.m., but they could change that time.	F 258	Weekly Audits will be conducted every week x 4 weeks and once a month x 3 months to monitor compliance of noise levels in facility. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. Executive Director is the responsible party Corrective Action will be completed by March 19th, 2014	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	F278 Resident R135 assessment will accurately reflect the residents range of motion status. All residents will be assessed and will accurately reflect the residents range of motion status. Assessment of all residents in facility was completed on February 7, 8, and 9, 2014. All nursing staff have been educated on the requirement to accurately identify and accurately assess range of motion status. Inservice education was completed on February 19 and 20, 2014. Education was provided by the DNS and DCE.	3-19-14

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F 278	Continued From page 4 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 residents (R135) reviewed who had visible contractures of the right hand/fingers. Findings include: R135 was not identified with contractures and was not provided services. However, was observed with contracture of 3 fingers on the right hand. A quarterly Minimum Data Set (MDS) dated 11/19/2013 was reviewed. R135's cognitive status was identified as severely cognitively impaired with limited assist of one staff for most activities of daily living. Functional limitations were identified as nothing noted for upper or lower extremities. Quarterly MDS for 8/21/2013 identified cognitive impairment as moderate, limited assist with activities of daily living and no functional limitations or impairment identified in the upper or lower extremities. Admission MDS dated 6/17/2013 identified R135 with moderate cognitive impairment, extensive assist of one staff for activities of daily living and no functional	F 278	Resident R135 MDS assessment was changed to reflect the change in range of motion and re-submitted on February 8, 2014. Weekly audits will be conducted every week x 4 weeks and once a month x 3 months and as needed thereafter to monitor residents range of motion status and to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	

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F 278	Continued From page 5 limitation or impairment in the upper or lower extremities. Also had been admitted on 5/17/2013 with diagnoses which included: heart failure, hypertension, dementia, and bacterial pneumonia. On 2/7/2014 at 3:15 p.m., MDS coordinator/registered nurse (RN)-B was interviewed regarding the assessment data for functional limitations for R135 (identified as having no limitations of upper and lower extremities). RN-B stated she depended on nursing documentation and physical therapy documentation regarding the range of motion and the functional limitations to complete the MDS. RN-B stated she looked at residents by passing them in the hallway but did not do a range of motion evaluation.	F 278	F280 Resident R133's catheter has been discontinued. Resident R133's care plan has been revised to include toileting care. All residents have the potential of being affected. All residents care plans with catheters will be reviewed and revised if needed by March 6, 2014. in regards to direct care staff related to catheter care. All nursing staff have been educated on catheter care. Inservices were held on February 19 and February 20, 2014. The DCE and DNS conducted the education. Weekly audits will be conducted once a week x4 weeks, then once a month for 3 months, then as needed thereafter to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	3-19-14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		

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F 280	Continued From page 6 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care in regards to direct staff related to catheter care for 1 of 2 residents (R133) reviewed with catheters. Findings include: R133 had an indwelling Foley catheter but lacked the revision of the catheter to direct staff related to personal cares. Urology physician note of 12/20/13 indicated R133 had a diagnosis of probable hypotonic (decreased tone) bladder with incomplete bladder emptying. R133 was observed on 2/6/14 at 7:35 a.m. during morning cares. Nursing assistant (NA)-A replaced the Foley catheter bedside bag with a leg bag and then dressed the resident. NA-A assisted R133 to wash face, but did not provide perineal cares which should include catheter tubing care to prevent urinary tract infections and irritation from catheter. The care plan printed 2/7/14 had a problem identified as self-care impairment that directed toileting assistance. A problem of urinary tract infection was identified. The interventions directed: 1) assist with toileting or incontinence care 2) catheter leg and bedside bag changed weekly 3) change Foley catheter every month. 4) provide indwelling catheter care every shift and	F 280		

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F 280	Continued From page 7 as needed. Secure catheter and tubing appropriately. The care plan did not direct staff to maintain aseptic technique while working with catheter and did not direct staff to provide perineal care. The nursing assistant worksheet provided 2/7/14 indicated R133 had a catheter, but did not direct staff related to care of the catheter, perineal cares, or changing the catheter bag. On 2/6/14 at 2:50 p.m. Director of nursing indicated the facility did not have a policy to direct staff on catheter care, changing urine leg and bedside bags, or providing perineal cares. Also she felt that perineal cares should be provided every shift.	F 280	F282 R139 catheter was removed. R139 has discharged from the facility to home. All residents with indwelling catheters have the potential of being affected. All residents care plans with catheters will be reviewed and revised if needed in regards to direct care staff related to catheter care. All will be reviewed and revised by March 9, 2014. All nursing staff have been educated on care plans and catheter care. Inservices were completed on February 19 and 20, 2014. The Education was completed by the DCE and DNS. Weekly audits will be completed on care plans once a week x4 weeks, then once a month x 3 months and as needed thereafter to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	3-19-14
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and document review, the facility failed to provide the use of a leg bag according to the plan of care for 1 of 1 residents (R139) reviewed with an indwelling catheter. Findings include: R139 was observed to have the urine bag higher than the bladder which allows the urine to drain back into the bladder which increases the chance of getting a urinary tract infection. R139 ' s care plan for having the urine	F 282		

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F 282	Continued From page 8 bag below the level of the bladder had not been provided by staff. On 2/6/14 at 7:45 a.m. R139 was in bed with head elevated and his knees bent. R139 had a urinary leg bag on his left lower leg and the urine bag was higher than the bladder at this time. On 2/7/14 at 7:11 a.m. R139 was observed to be in bed with his clothes on and the head of the bed elevated with knees bent. The leg bag was observed to be on his left leg, above the knee and again put the urine bag above the bladder. Licensed practical nurse (LPN)-B came into the room to check on resident and stated that the nursing assistant should have put an extender on the catheter tubing. The extender would allow the urine bag to be placed lower than the bladder and reduce the chance of urine draining back into the bladder. R139 ' s care plan dated 2/1/14 indicated that there was an alteration in elimination of bladder related to an indwelling urinary catheter placed on 2/1/14 related to inability to void and unable to in and out catheterize related to resistance, history of urinary tract infections, and urinary retention. The goal would have R139 free of urinary tract infection, and would have no complications from use of indwelling catheter such as pain, infection, obstruction. Interventions included anchoring the catheter, avoiding excessive tugging on the catheter during transfer and deliver of care. The staff was instructed to check the catheter tubing for proper drainage and positioning and to keep the drainage bag of the catheter below the level of the bladder at all times. R139's signed physician order sheet dated 1/14/14 included the diagnosis of unspecified disorder of kidney and ureter.	F 282		

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F 282	Continued From page 9 On 2/7/14 at 2:10 p.m., it was observed and LPN-D confirmed that R139 was wearing a leg bag that was not an anti-reflux urinary leg bag. The director of nursing was informed of the concern with R139 not receiving cares as directed in the comprehensive care plan and also had been asked to provide a policy for residents who use an indwelling catheter and care and treatment. None had been provided.	F 282	F285 Resident R101 preadmission screening was obtained but not placed on the PASSR form. The preadmission is in the chart as of February 8, 2014. All residents have the potential to be affected.	3-19-14
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--	F 285	All residents with a mental illness diagnosis will have a preadmission screening completed before admission to facility to determine what mental illness services may be required. Random weekly audits will be conducted to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	

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F 285	Continued From page 10 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure preadmission screening completed for 1 of 1 resident (R101) who was admitted with a mental illness diagnosis. Findings include: R101 was identified by the facility to have a mental illness diagnosis without a level 2 preadmission screening completed to determine what mental illness services they may have required. R101 was admitted 6/16/11, with diagnosis that included bipolar disorder and schizoaffective disorder according to facility Medical Diagnosis List and according to the facility Admission Record Diagnosis Information. The facility identified R101 on the quarterly Minimum Data Set (MDS), an assessment dated	F 285		

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F 285	Continued From page 11 11/26/13, to have diagnosis that included manic depression and schizophrenia, received antipsychotic and, antidepressant medication. Document review of resident care plan initiated 12/23/10, directed staff R101 was at risk for alteration in mood, currently received psychotropic medications and mental health services, interventions included psych services as needed. Care plan initiated 11/28/11, directed staff R101 was at risk for alteration in behaviors, interventions included refer to psychologist/psychiatrist as needed. Document review of facility Psychotropic Dose Reduction Review dated 1/2/14; revealed R101 was regularly seen by psychology and psychiatry at least monthly. Document review of facility Psychosocial Progress Note/Quarterly dated 12/30/13, revealed R101 exhibited moods, was involved with mental health services, and diagnosis of schizoaffective disorder. During interview on 2/6/14, at 11:40 a.m., the interim director of nursing verified the facility lacked level 2 preadmission screening for R101. During interview at that time, social services (SS)-A stated the procedure was that the hospital completed preadmission screening and then a referral made by the hospital to the county to complete a level 2 screening. Document review of hospital "Social Work Hospital Service Progress Note" dated 12/8/10, which identified plan: #3. "Anticipate that Golden East will be able to admit after the level 2 screening is completed."	F 285		

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	245184	A. BUILDING _____ B. WING _____ MAR 14 2014 MN Dept of Health Rochester	02/07/2014

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F 285	Continued From page 12 During interview on 2/7/14, at 8:55 a.m., SS-A verified the facility lacked evidence of level 2 screening completed. SS-A stated she had just called the county now to obtain level 2 screening.	F 285	F309 Resident R116 fluid restrictions will be monitored according to physician orders. All residents have the potential to be affected. Fluid restrictions will be monitored for all residents with end stage renal disease Weekly audits will be conducted once a week x 4 weeks, then once a month for 3 months and as needed thereafter to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	3-19-14
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation, the facility failed to provide end stage renal disease care and treatments to meet the health needs of 1 of 1 resident (R116) who received dialysis services due to renal failure. Findings include: R116 was on a fluid restriction of 1.2 liters (approximately 5 eight ounce cups per day) however, the facility did not have a system in place to identify how much fluids dietary and nursing would give R116 each day to keep fluid intake to 1.2 liters nor was anyone keeping a record of the fluid intake to determine if R116 was maintaining no more than 1.2 liters per day. Physician orders dated 1/31/14 instructed resident was to have a dialysis diet with a 1.2 liter fluid restriction was admitted on 1/16/14 and had a diagnosis of end stage renal disease (ESRD)	F 309		

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F 309	Continued From page 13 and now dialysis dependent, hypertension, chronic atrial fibrillation. R116 admission Minimum Data Set (an assessment of needs) dated 1/23/14 indicated that R116's brief interview for mental status (BIMS) was 15 which indicated cognitively intact. Also the MDS assessment showed R116 needed supervision with bed mobility, walking in room and corridor, dressing, eating and independent with personal hygiene. The nutrition assessment dated 1/16/14 indicated that R116 was overweight related to decreased activity level and debility as evidenced by body mass index (BMI) of 40.2. Nutrition interventions included dialysis with 1.2 liter fluid restriction. Nutrition goals were to comply with diet restrictions and fluid restrictions per recommendations. On 2/6/14 R116 was observed at 2:02 p.m. eating his lunch after returning from dialysis. R116 stated that dialysis run had gone well. R116's lunch included carrots, meat with gravy, potatoes, applesauce and water with his medicine. R116 also had 3 cups/mugs of fluids - consisting of milk, juice and coffee, each mug was at least ¾'s full (which was a total of 18 ounces of fluids). During an interview on 2/7/14 at 3:00 p.m. registered dietician (RD) stated that the cups R116 was using held 8 ounces of fluid. The RD stated that R116 should not have received all those fluids and that staff needed education. The meal tray cards indicated that R116 was on a fluid restriction diet of 1.2 liters and that R116 was to have 4 ounces of juice and 4 ounces of water for lunch which was a total of 8 ounces (however, R116 received twice the amount of fluids at this meal.)	F 309		

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F 309	Continued From page 14 The care plan dated 1/27/14 indicated R116 had a risk for fluid output exceeding intake and instructing staff that R116 currently was on a 1.2 liter fluid restriction daily. One of the interventions instructed staff to provide R116 to have a 1.2 liter fluid restriction. The care plan dated 2/4/12 indicated a problem of alteration in kidney function due to end stage renal disease evidenced by hemodialysis. Interventions instructed staff to provide a diet and fluid restrictions as ordered by physician. Encourage patient to follow nutritional and hydration program interventions. A care plan dated 2/4/14 indicated R116 had a potential for alteration in hydration related to: edema, end stage renal disease, fluid restriction. Interventions instructed staff to maintain fluid restriction per physician order. Provide diet, fluids, per physician orders. During an interview on 2/6/14 at 1:55 p.m. with nurse aide (NA)-C, she stated that staff give fluid to R116 following the tray cards. NA-C indicated that the nurses know how much to give R116 with medications. Registered nurse (RN)-A, during an interview on 2/6/14 at 1:59 p.m., stated that she was not aware that R116 was on a fluid restriction. RN-A stated that she did not have any order to check off intake of fluids for R116. During an interview with the RD on 2/6/14 at 2:33 p.m., RD stated that the fluid restriction of R116 is on the resident ' s dietary cards and is on his care plan. The RD confirmed that no staff was keeping track of R116 ' s fluid intake daily. During an interview with R116 on 2/6/14 at 7:35	F 309		

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F 309	Continued From page 15 a.m., the resident indicated he had dialysis three times a week. He did not recall if he took medicine before his dialysis. R116 stated that they don't want him to retain fluids so that is why he figures part of his weight is due to fluids. R116 stated that they (facility staff), took all his water away last night. Before last night they weren't so strict. R116 stated he understands why he is on a fluid restriction. The director of nursing (DON) during an interview on 2/6/14 at 2:48 p.m. indicated that she would expect the nurses to be monitoring R116's fluid intake. An undated policy titled Fluid Restriction had been provided and no instruction on who would monitor a resident's fluid intake while on a fluid restriction.	F 309	F315 Resident R111 will receive toileting services per care plan. Resident R133 catheter has been removed. Resident R139 is no longer in the facility, catheter was removed before discharge from facility. All residents have the potential to be affected. All residents will receive toileting per care plan. All residents with indwelling catheters will receive bladder treatments and services per care plan.	3-19-14
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review, the facility failed to provide necessary	F 315	Random weekly audits will be conducted to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	

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F 315	Continued From page 16 toileting services for 1 of 3 residents (R111) reviewed for incontinence; the facility failed to provide bladder treatments and services for 2 of 2 residents (R133, R139 who had indwelling urinary catheters. Findings include: R111 did not receive toileting services in accordance with the plan of care. Review of the quarterly Minimum Data Set (MDS) dated 1/14/14 indicated R111 had diagnoses that included Alzheimer's; was unable to participate in the brief interview of mental status (BIMS); had long and short term memory impairment; was frequently incontinent of bladder; and did not participate in a toileting program. On 2/5/14 at 9:20 a.m. R111 was noted to be lying fully dressed on back in bed. Odor of bowel movement (BM) was noted. On 2/6/14 at 8:30 a.m. R111 was receiving morning personal cares. The room had an odor of urine. Nursing assistant (NA)-B stated R111 was assisted to the chair using a standing lift. NA-B stated the resident had been incontinent of urine this am. NA-B stated R111 would at times tell staff when needed to have a bowel movement, but not if need to void urine. NA-B stated staff did not put R111 on the toilet unless the resident asked. NA-B verified she had not toileted R111 when she got R111 up from bed. The care plan dated 10/24/13 was provided 2/7/14. The care plan identified a problem of urinary tract infections initiated 6/18/13. Approaches/interventions directed staff to assist resident with toileting or incontinence as needed. Toilet resident upon waking, before and after meals, prior to activities, before bed and every	F 315		

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F 315	Continued From page 17	F 315		

two hours during the night. A second care plan provided 2/7/14 and dated as printed 2/7/14 showed no changes. The nursing assistant worksheet provided 2/7/14 indicated R111 was to be toileted every two hours.

Licensed practical nurse who was the clinical manager for third west wing was interviewed on 2/714 at 9:30 a.m. stated staff was to offer toileting every 2 hours.

CATHETER CARE WAS NOT PROVIDED TO PREVENT URINARY TRACT INFECTIONS:

R133 received personal cares and changing of catheter bags, but did not receive perineal care and did not receive care to prevent cross contamination.

Urology physician note of 12/20/13 indicated a diagnosis of probably hypotonic (having less than normal tone) bladder with incomplete bladder emptying. During an interview on 2/4/14 at 1:00 p.m. the licensed practical nurse/clinical manager (LPN/CM) of the third west unit stated R133 had an indwelling Foley catheter because of urine retention and inability to void.

R133 was observed on 2/6/14 at 7:35 a.m. during morning cares. R133 ' s leg catheter bag was observed not to have a cap on the insertion port to protect it from infections. The bladder tubing was observed to be wrapped in a wash cloth that had been used by NA-A to wipe the residents face. The bladder tubing with wash cloth was then placed on the bed between the residents legs. NA-A was observed to continue dressing R133 without changing her soiled gloves and again without changing her gloves touch the

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F 315	Continued From page 18 bladder tubing to attach the tubing to the leg bag. In addition during the personal cares, no perineal care was provided to R133. At 7:45 a.m. NA-A stated the catheter bag tip cover was in the plastic bag in the bathroom. NA-B stated the catheter bag tip and catheter tip should have been wiped with an alcohol pad before attaching them. On 2/6/14 at 9:20 a.m. the LPN/CM on third floor west stated the bag and tubing were stored in a garbage bag and that there was a cap to be placed on the insertion port to protect the tubing. LPN/CM also stated alcohol wipes were to be used to cleanse the tubing and tips. On 2/16/14 at 2:50 p.m. the director of nursing was interviewed. She indicated the facility did not have a policy related to changing catheter bags. DON also stated the indwelling catheter policy did not direct care of the catheter and perineal care for residents with the indwelling catheter. DON stated she would expect perineal care to be completed once a shift for all residents with indwelling catheter. R139 did not receive catheter care to prevent urinary tract infection with the use or a urinary catheter leg bag. R139's signed physician order sheet dated 1/14/14 indicated that diagnoses included acute, unspecified disorder of kidney and ureter also R139 was admitted on 6/27/13. R139 ' s quarterly Minimum Data Set dated 12/30/13 indicated R139 had a brief interview for mental status (BIMS) of 11 which was cognitively intact. R139 was independent with bed mobility, transfers, and ambulation. R139 was extensive assist with personal hygiene. Nurses notes dated 2/1/14 indicated resident was	F 315		

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F 315	Continued From page 19 complaining of urgency to void but when attempting to void resident could only go small amounts. The nurse attempted to in/out catheterize resident but was unable, and met blockage of some type. Resident was sent to the emergency room. R139 returned to nursing home with a diagnosis of a urinary tract infection and was started on Cipro (antibiotic) 250 mg twice a day for 7 days and had a urinary catheter placed. On 2/6/14 at 7:45 a.m. R139 was in bed with head elevated and his knees bent. R139 had a urinary leg bag on his left lower leg which was higher than his bladder in this position. During an interview with a licensed practical nurse (LPN)-B on 2/6/14 at 11:15 a.m. she indicated that R139 is to be in bed with his legs straight. LPN-B did not know if the urinary bag had an anti-reflux on it (but was found later to not have an anti-reflux valve so the urine in the bag could flow back into the bladder if the urine bag was higher than the bladder.) She sated she instructed and reminds R139 and staff to elevate head of bed and make sure his legs are straight to keep the urine bag lower than the bladder. During an interview with LPN-D on 2/6/14 at 11:15 a.m. she stated that they currently do not have leg bags that are anti-flow /reflux in their facility, however she was able to contact a supplier and they will be shipping out a case of them that would be delivered the following day. The Medline leg bag in the bag had no mention as to whether it prevents reflux. Nurses notes dated 2/5/14 indicates that R139 continues on an antibiotic, Cipro, for the treatment of a urinary tract infection. R139 is	F 315		

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F 315	Continued From page 20 reminded when in bed to keep his legs straight and his head of bed elevated so the urine can drain properly into his leg bag. On 2/7/14 at 7:11 a.m. R139 was observed to be in bed with his clothes on and the head of the bed elevated with knees bent. The leg bag was observed to be on his left leg, above the knee. R139 ' s comprehensive care plan dated 2/1/14 indicated that there was an alteration in elimination of bladder related to an indwelling urinary catheter placed on 2/1/14 related to inability to void and unable to in and out catheterize related to resistance, history of urinary tract infections, and urinary retention. The goal would have R139 free of urinary tract infection, and would have no complications from use of indwelling catheter such as pain, infection, obstruction. Interventions included anchoring the catheter, avoiding excessive tugging on the catheter during transfer and deliver of care. The staff was instructed to check the catheter tubing for proper drainage and positioning and to keep the drainage bag of the catheter below the level of the bladder at all times. On 2/7/14 at 2:10 p.m., it was observed and LPN-D confirmed that R139 was wearing a leg bag that was not an anti-reflux urinary leg bag, The director of nursing (DON) was informed of R139 ' s urine possibly draining back into the bladder when the urine bag was higher than the bladder and the DON was requested to provide a policy for the use of leg bags that were not anti-reflux but one was not provided.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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F 318	Continued From page 21 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a resident's range of motion or need for a restorative services and develop such a program for 1 of 1 resident (R135) identified with limited range of motion of upper extremities. Findings include: R135 lacked an assessment and development of range of motion services for upper extremity functional limitations. On 2/5/2014 at 10:53 a.m., R135's right hand and fingers were observed to be contracted. The resident had no brace or splint on the hand. On 2/7/2014 at 8:45 a.m., R135 was observed to be eating using the left hand. The right hand lay in the lap and in a fisted position. The resident was interviewed and indicated the right hand did not hurt and no pain. A quarterly Minimum Data Set (MDS) dated 11/19/2013 was reviewed. R135's cognitive status was identified as severely cognitively impaired with limited assist of one staff for most activities of daily living. Functional limitations were identified as nothing for upper or lower extremities. Quarterly MDS for 8/21/2013 identified cognitive impairment as moderate,	F 318	F318 An assessment for range of motion will be provided for resident R135. Resident R135 will receive appropriate treatment and services to increase range of motion and/or to prevent range of motion. All residents with a limited range of motion will receive appropriate treatment and services to increase range of motion and/or to prevent range of motion. Weekly audits will be conducted to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	3-19-14

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F 318	Continued From page 22 limited assist with activities of daily living and no functional limitations or impairment identified in the upper or lower extremities. Admission MDS data set dated 6/17/2013 identified the resident with moderate cognitive impairment, extensive assist of one staff for activities of daily living and no functional limitation or impairment in the upper or lower extremities. Also included admission on 5/17/13. R135's care plan with completed date of 11/29/2013 was reviewed. It identified a physical functioning deficit related to self-care impairment, and mobility impairment. The interventions addressed a restorative program for ambulation but did not address the right hand/finger contractures. No physician note since admission was evident in the medical record that would address the contracture of the right hand. However, on 12/13/2013, the physician ordered " mitts " that could be heated and used for comfort. On 2/6/2014 at 7:35 a.m., a nurse aide (NA)-E prepared R135's warm water to wash and set it on the Rollator walker seat. The resident was washing up using left hand with some assist from the right hand. NA-E stated the resident could do some things but it depended on the day and NA-E assisted the resident with the back and peri area. At 8:05 a.m. NA-E as interviewed regarding doing range of motion or doing any treatment to the resident's right hand. She stated she didn't do range of motion but at least once a shift she would put on the heated glove (light blue mitt) and stated it was heated up in the microwave.	F 318		

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F 318	Continued From page 23 On 2/6/2014 at 12:45 p.m., NA-F stated she did not do anything with the resident ' s right hand except wash it real good. She did not do range of motion or any kind of treatment such as the heated gloves. Social services (SS)-X was interviewed on 2/7/2014 at 9:10 a.m. regarding use of the heated gloves for R135. The SS-X indicated the family applied the heated gloves because the facility staff cannot do that here. The facility didn ' t do things with heat. She indicated physical therapy and occupational therapy seen the resident and should check with them. The family bought the heating gloves on their own and brought them in. On 2/7/2014 at 10:40 a.m. the occupational rehab director (ORD) provided information and stated the resident was not seen for a contracture of the right hand. The information did not identify the resident had a contracture of the right hand/fingers. On 2/7/2014 at 10:45 a.m., the assistant director of nursing (ADON) was interviewed. She stated the resident did not have a contracture of the right hand. The resident used that hand. I, the surveyor had not seen the resident use the right hand at all. We went up to the resident's room and asked the resident to open the right hand. The third, fourth and little finger, R135 could not straighten out. The resident indicated it didn't hurt. The resident did not have anything in the hand but it was a closed fist. The ADON had observed that with the surveyor. The ADON indicated she would call the OT rehab director, which she did. At 10:55 a.m., the ORD was informed about what the ADON and the surveyor observed and she indicated she would take a	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 318	Continued From page 24 look at it. All nursing notes from admission through 2/7/2014 were reviewed. Nothing was documented as far as contractures of the right hand/fingers. On 2/7/2014 at 1:00 p.m., the ORD director was interviewed and stated she verified she did not find any documentation about the right hand/finger contracture. On 2/7/2014 at 2:50 p.m., NA-G had not noticed any problems with R135. NA-H seen the resident rubs hands and the resident could open the left hand but not the right hand. Registered nurse (RN)-A, thought that both hands were contracted but able to use cup and walk with walker and required limited assistance. RN- A indicated the resident's hands had been that way since she started in 5/2013. On 2/7/2014 at 2:55 p.m., R135 ' s family (F)-A was interviewed regarding the resident's right hand/finger contractures. F-A stated R135 has had those for 5 years or so but had gotten worse in the last 3 years. R135 was admitted to the facility with the right hand like that. F-A thought physical therapy (PT) worked on that and it didn't help. But as a family, the only thing they found that helped was the heating mitts. She indicated the family put the mitts on when they visit because the facility stated they couldn't do it. The mitts seemed to help with the discomfort. Staff knew about R135 because they helped the family with the mitts. On 2/7/2014 at 3:00 p.m. the occupational rehab director (ORD) was interviewed on the assessment of range of motion for residents. She indicated nursing did the range of motion for	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____ MAR 14 2014 MN Dept of Health Rochester	02/07/2014

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GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 318	Continued From page 25 the MDS. According to the ORD, the resident was discharged on 7/1/2013 from Occupation therapy services and she didn't ever remember seeing any issues with R135 ' s right hand. They (facility staff) would not do the gloves because they couldn't do continual monitoring but nurses could do it if they could monitor it. No one has approached her about evaluating the hand. On 2/7/2014 at 3:15 p.m., MDS coordinator/register nurse (RN)-B was interviewed regarding the assessment data for functional limitations being no limitations of upper and lower extremities. RN-B depended on nursing documentation and physical therapy documentation regarding the range of motion functional limitations for the MDS assessment. RN-B stated she looked at residents by passing them in the hallway but did not do a range of motion evaluation.	F 318	F323 Resident R9 is no longer a patient here. He has been discharged to home. All residents have the potential to be affected. All residents with a falls occurrence will receive a thorough investigation and appropriate interventions will be implemented to reduce injury from falls. Inservices on falls and interventions was completed with nursing staff on February 19 and 20, 2014. The DNS and DCE conducted the education. Falls are reviewed every day during morning standup meeting by the interdisciplinary team. Weekly audits will be conducted once a week x 4 weeks, then once a month x 3 months and as needed thereafter to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	3-19-14
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to investigate and ensure interventions were effective and implemented to reduce falls incidents for 1 of 1 residents (R9)	F 323		

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F 323	Continued From page 26 reviewed with chronic falls. Findings include: R9 was hospitalized after a fall and the facility did not do a thorough investigation or determine if current interventions used were effective. The Minimum Data Set (MDS) on admission dated 12/20/2013 was reviewed. It identified the resident as moderately cognitively impaired. R9 required extensive assist of 2 staff for most activities of daily living except eating was supervision of one staff and limited assist of one for personal hygiene and walking in room. The resident was frequently incontinent of urine with no toileting program and had a history of falls. An Incident report dated 1/10/2014 at 2:00 p.m. was reviewed. It noted R9 was attempting to self-transfer, had a history of falls, and impaired safety. The resident had socks on, and had a device and was not in use (according to staff, it was a walker.) It was reviewed by the facility staff and recommendations were to apply bed/chair alarm to remind resident not to transfer without assistance. Another incident occurred on 1/10/2014 at 10:05 p.m. According to the note, the resident lost balance and slipped and was on the floor. The resident had a history of falls, impaired safety awareness, was attempting to self- transfer, had socks on, and had a device and was not in use (walker.) The resident complained of pain in the mid right hip area and was sent to the hospital. R9 remained there until 1/17/2014. Post Fall Recommendations and interventions were identified as: pain assessment, assistive device within reach, bed in low position, call light within reach, and bed/chair alarm.	F 323		

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F 323	Continued From page 27 The hospital dismissal summary dated 1/17/2014 noted: mechanical fall, not secondary to syncope. The resident developed increased mental status changes. Metabolic and infectious courses were ruled out. Sleep enhancement was encouraged. 1:1 monitoring for safety was done. X-rays were negative. An electrocardiogram was done. Physical medicine was consulted and recommends 24 hour supervision, in skilled facility. Due to confusion and impulsivity R9 required 1:1 supervision. Many other consultations were done (psychiatry, neurology, and cardiology.) R9 ' s care plan with initiation date of 12/23/2013 identified: At risk for falls related to fall in the past 30 days and new environment. Interventions: Bed and chair alarms, bed low position, call light available, contour mattress, encourage calling for assistance, footwear to prevent slipping, keep environment well lit and free of clutter, orientation to new room, therapy referral, and walker near resident. On 2/6/2014 at 3:15 p.m., the assistant director of nursing (ADON) stated she could assure the surveyor that R9 did have bed/chair alarms put on after the fall on 1/10/2014 at 2:00 p.m. However, no documentation could substantiate that. When she reviewed the post fall incident report and investigative report she stated it did not say whether the alarms were in use and sounding at the time of the fall. On 2/7/2014 at 8:20 a.m., the director of nursing (DON) indicated when she came; the staff was questioned about how they do incident reports. They were writing them out for everything. The staff did not know of any system.	F 323		

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F 323	Continued From page 28 On 2/7/2014 at 10:25 a.m., ADON was interviewed regarding the system for incident reporting. She stated the staff fills out incident report, checklist, symptoms, background, VS (vital signs), and response. For fall: interventions for future fall. The staff is to call the director of nursing and then would be reported to the state if advised to report. The next day, clinical manager would review at morning meetings, and discuss about interventions. The nurse would write what the resident was possibly doing. The facility just started a nursing assistant sheet that asked questions of nursing assistant for their view of the incident. The incident reports were reviewed with the ADON and did not address if the alarm was sounding at the time of the incident or not. The ADON said it wasn't documented whether the alarm was sounding or not. She verified there was a lack of information for the 2nd fall. After review of the nursing notes of the incident, the ADON verified the second fall notes were not detailed and the fall was not documented to provide all the information of the incident. Staff needed some more training.	F 323	F425 Residents R8 and R9 have discharged from the facility. All residents have the potential to be affected. All residents will receive accurate dispensing of medications. Education was completed with licensed nursing staff on February 19 and February 20, 2014. The education was conducted by the DCE and DNS. Random weekly audits once a week x4 weeks, then once a month x 3 months and as needed thereafter will be conducted to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by March 19th, 2014	3-19-14
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		

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F 425	Continued From page 29 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications were administered without error for 2 of 6 residents (R8 and R91) whose medication administration was observed during medication pass. Findings include. R8 was found to have Lidoderm patch left on the skin beyond the recommended physicians order. R8 had a physician's order for Lidoderm patch 5% apply to lower back topically every 12 hours for pain related to lumbago. Leave on for up to 12 hours in one 24 hour period. R8 had diagnoses outlined on the 1/19/14 discharge summary osteoporotic compression fracture with the back, dementia. Licensed practical nurse (LPN) - A was observed on 2/6/14 at 7:14 a.m. applying the Lidoderm patch to R8's back. R8 still had a patch on lower back dated 2/5/14. LPN-A stated patch had been applied the day before and not removed.	F 425		

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F 425	Continued From page 30 The nurse practitioner (NP)-Z was interviewed on 2/6/13 at 8:49 a.m. NP stated she had been told that Lidoderm would have adverse effects to someone who had liver problems, but she was unsure of R8's medical issues. NP-Z stated the patch should have been removed after 12 hours. NP-Z provided a copy of Micromedix (Evidence-Based Resources) information related to Lidoderm. Per NP this is the information that she uses. Micromedix stated the drug would be excreted through the kidney and metabolized by the liver. The Micromedix indicated the patch was to be "applied to intact skin and remove patch after a maximum of 12 hours of application within a 24-hour period." R91 had received Fluoxetine HCl 20 mg each day but had a physician ' s order for 30 mg per day and the wrong dose had been given for over a year without clarifying the order with the physician. Document review of signed physician orders dated 1/14/14; revealed orders for fluoxetine HCl 20 milligrams 1.5 tablets (30 milligrams) by mouth daily with order start date of 12/4/12 and R91 had a diagnosis of depression. During observation of the medication pass on 2/6/14, at 8:07 a.m., licensed practical nurse-C (LPN-C) administered fluoxetine, an antidepressant medication, and 20 milligrams by mouth to R91. During interview at that time, LPN-C verified the medication label was fluoxetine 20 milligrams (mg). Document review of physician orders revealed	F 425		

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F 425	Continued From page 31 orders for fluoxetine 20 milligrams 1 ½ tablets, with start date of 12/4/12. Document review of the facility medication administration record (MAR) for 12/13, 1/14, and 2/14, revealed fluoxetine HCl (20 mg) 1.5 tab (30 mg) by mouth once daily with order date of 12/4/12. During interview on 2/6/14, at 1:54 p.m., LPN-C verified physician orders for fluoxetine 20 milligrams 1 ½ tablets. She verified the order start date was 12/4/12, a period of 14 months without the physician ordered 30 milligrams of antidepressant. Document review of facility policy Monthly Medication Review Guideline dated 1/11, read, "Medication orders will be reconciled monthly prior to beginning use of the new monthly Medication Administration Records and Treatment Administration Records to ensure accuracy. This reconciliation will be a three way check system that compares the medical record to current and new medication administration records." 1. New Medication Administration Records (MAR) and Treatment Administration Records (TAR) are printed. 2. The current MAR and TAR is compared to the newly printed MAR and TAR to determine if all changes are reflected on the new MAR/TAR. 3. The physician order and progress note section of the medical record is reviewed for any changes to determine if there have been any orders not captured on the current and/or new MAR/TAR. Monitoring for Compliance-the nurse signs and dates physician order sheet to indicate reconciliation/review of medications.	F 425		

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F 425	Continued From page 32 During interview on 2/7/14, at 2:13 p.m., interim director of nursing stated she expected staff to check medication orders and fix any discrepancies.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST** **ROCHESTER, MN 55904**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - Rochester East was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. POC ok TS 3-18-14	

DOC: 3-19-14
EXIT: 2-7-14

RECEIVED
MAR 17 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	3-12-14

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

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2014**

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - Rochester East, is a 3-story building with a full basement. The facility was built in 1968 and was determined to be of Type II(222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 105 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 2 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 20 out of 105 residents. Findings include: On facility tour between 8:30 AM and 12 noon on 02/05/2014, observation revealed that the following was found: 1. Basement - storage/repair shop - over 50 square feet, open penetrations around pipes on north and west walls 2. Basement - activities storage room - over 50 square feet - no automatic door closer These deficient practices were confirmed by the Facility Maintenance Director (RE) at the time of	K 029	K029 1. Open penetrations in the storage/repair shop have been repaired. Completion date of 3-7-14 2. Automatic closure device has been installed on the basement-activity storage room door. Completion date of 3-7-14 The Maintenance Director will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	3-7-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

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K 029	Continued From page 3 discovery.	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 105 residents. Findings include: On facility tour between 8:30 AM and 12 noon on 02/05/2014, the review of the fire drill documentation for the past 12 months (February 2013 to January 2014) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: Evening: 1545, 1615, 1945 and 1555 hours Nights: 2300, 0400, 0330 and 2330 hours	K 050	K050 1. Fire Drills will be conducted at sufficient various times and shifts. 2. Maintenance Director has been in serviced on completing fire drills at sufficient varying times and shifts. Completion date of 3-7-14 3. Maintenance Director will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	3-7-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 4 This deficient practice was confirmed by the Facility Maintenance Director (RE) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8538

March 6, 2014

Mr. Shane Roche, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Re: Enclosed State Nursing Home Licensing Orders - Project Number

Dear Mr. Roche:

The above facility was surveyed on February 3, 2014 through February 7, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5184077 that was found to be unsubstantiated and complaint number H5184074 that was found substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health,

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	02/07/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 3, 4, 5, 6 and 7 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	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
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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904. c/o Gary Nederhoff, Unit Supervisor 507-206-2731 Office Investigation/s of complaint H5184074 and H5184077 had been completed during this licensing survey and had not been substantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's	2 540		

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2 540	Continued From page 2 comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 residents (R135) reviewed who had visible contractures of the right hand/fingers. Findings include: R135 was not identified with contractures and was not provided services. However, was observed with contracture of 3 fingers on the right hand. A quarterly Minimum Data Set (MDS) dated 11/19/2013 was reviewed. R135's cognitive status was identified as severely cognitively impaired with limited assist of one staff for most activities of daily living. Functional limitations were identified as nothing noted for upper or lower	2 540		

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2 540	Continued From page 3 extremities. Quarterly MDS for 8/21/2013 identified cognitive impairment as moderate, limited assist with activities of daily living and no functional limitations or impairment identified in the upper or lower extremities. Admission MDS dated 6/17/2013 identified R135 with moderate cognitive impairment, extensive assist of one staff for activities of daily living and no functional limitation or impairment in the upper or lower extremities. Also had been admitted on 5/17/2013 with diagnoses which included: heart failure, hypertension, dementia, and bacterial pneumonia. On 2/7/2014 at 3:15 p.m., MDS coordinator/registered nurse (RN)-B was interviewed regarding the assessment data for functional limitations for R135 (identified as having no limitations of upper and lower extremities). RN-B stated she depended on nursing documentation and physical therapy documentation regarding the range of motion and the functional limitations to complete the MDS. RN-B stated she looked at residents by passing them in the hallway but did not do a range of motion evaluation. SUGGESTED METHOD OF CORRECTION: The MDS (minimum data set) coordinator could ensure the comprehensive assessments of resident's included an accurate identification of significant impairments in functional capacity. The MDS coordinator could involve nursing staff and physical therapy staff in the assessments. A random audit of resident's identified with functional limitations could be developed and implemented. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 540		

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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based upon observation, interview, and document review, the facility failed to provide the use of a leg bag according to the plan of care for 1 of 1 residents (R139) reviewed with an indwelling catheter. Findings include: R139 was observed to have the urine bag higher than the bladder which allows the urine to drain back into the bladder which increases the chance of getting a urinary tract infection. R139 ' s care plan for having the urine bag below the level of the bladder had not been provided by staff. On 2/6/14 at 7:45 a.m. R139 was in bed with head elevated and his knees bent. R139 had a urinary leg bag on his left lower leg and the urine bag was higher than the bladder at this time. On 2/7/14 at 7:11 a.m. R139 was observed to be in bed with his clothes on and the head of the bed elevated with knees bent. The leg bag was observed to be on his left leg, above the knee and again put the urine bag above the bladder. Licensed practical nurse (LPN)-B came into the room to check on resident and stated that the nursing assistant should have put an extender on the catheter tubing. The extender would allow the urine bag to be placed lower than the bladder and reduce the chance of urine draining back into the	2 565		

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2 565	Continued From page 5 bladder. R139 ' s care plan dated 2/1/14 indicated that there was an alteration in elimination of bladder related to an indwelling urinary catheter placed on 2/1/14 related to inability to void and unable to in and out catheterize related to resistance, history of urinary tract infections, and urinary retention. The goal would have R139 free of urinary tract infection, and would have no complications from use of indwelling catheter such as pain, infection, obstruction. Interventions included anchoring the catheter, avoiding excessive tugging on the catheter during transfer and deliver of care. The staff was instructed to check the catheter tubing for proper drainage and positioning and to keep the drainage bag of the catheter below the level of the bladder at all times. R139's signed physician order sheet dated 1/14/14 included the diagnosis of unspecified disorder of kidney and ureter. On 2/7/14 at 2:10 p.m., it was observed and LPN-D confirmed that R139 was wearing a leg bag that was not an anti-reflux urinary leg bag. The director of nursing was informed of the concern with R139 not receiving cares as directed in the comprehensive care plan and also had been asked to provide a policy for residents who use an indwelling catheter and care and treatment. None had been provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could ensure the nursing staff follow each resident's care plan as written. Audits of nursing staff giving care could be completed on a regular basis. Nursing staff could be given education on the importance of following individual resident care plans as written.	2 565		

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2 565	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care in regards to direct staff related to catheter care for 1 of 2 residents (R133) reviewed with catheters. Findings include: R133 had an indwelling Foley catheter but lacked the revision of the catheter to direct staff related to personal cares. Urology physician note of 12/20/13 indicated R133 had a diagnosis of probable hypotonic (decreased tone) bladder with incomplete bladder emptying. R133 was observed on 2/6/14 at 7:35 a.m. during morning cares. Nursing assistant (NA)-A	2 570		

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2 570	Continued From page 7 replaced the Foley catheter bedside bag with a leg bag and then dressed the resident. NA-A assisted R133 to wash face, but did not provide perineal cares which should include catheter tubing care to prevent urinary tract infections and irritation from catheter. The care plan printed 2/7/14 had a problem identified as self-care impairment that directed toileting assistance. A problem of urinary tract infection was identified. The interventions directed: 1) assist with toileting or incontinence care 2) catheter leg and bedside bag changed weekly 3) change Foley catheter every month. 4) provide indwelling catheter care every shift and as needed. Secure catheter and tubing appropriately. The care plan did not direct staff to maintain aseptic technique while working with catheter and did not direct staff to provide perineal care. The nursing assistant worksheet provided 2/7/14 indicated R133 had a catheter, but did not direct staff related to care of the catheter, perineal cares, or changing the catheter bag. On 2/6/14 at 2:50 p.m. Director of nursing indicated the facility did not have a policy to direct staff on catheter care, changing urine leg and bedside bags, or providing perineal cares. Also she felt that perineal cares should be provided every shift. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could ensure nursing staff revise resident care plans when indicated and in a timely manner. Audits could be preformed to ensure staff were in compliance. TIME PERIOD FOR CORRECTION: Twenty One	2 570		

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2 570	Continued From page 8 (21) days.	2 570		
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 observation, interview and documentation, the facility failed to provide end stage renal disease care and treatments to meet the health needs of 1 of 1 resident (R116) who received dialysis services due to renal failure. Findings include: R116 was on a fluid restriction of 1.2 liters (approximately 5 eight ounce cups per day) however, the facility did not have a system in place to identify how much fluids dietary and nursing would give R116 each day to keep fluid intake to 1.2 liters nor was anyone keeping a record of the fluid intake to determine if R116 was maintaining no more than 1.2 liters per day. Physician orders dated 1/31/14 instructed resident was to have a dialysis diet with a 1.2 liter	2 830		

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2 830	Continued From page 9 fluid restriction was admitted on 1/16/14 and had a diagnosis of end stage renal disease (ESRD) and now dialysis dependent, hypertension, chronic atrial fibrillation. R116 admission Minimum Data Set (an assessment of needs) dated 1/23/14 indicated that R116's brief interview for mental status (BIMS) was 15 which indicated cognitively intact. Also the MDS assessment showed R116 needed supervision with bed mobility, walking in room and corridor, dressing, eating and independent with personal hygiene. The nutrition assessment dated 1/16/14 indicated that R116 was overweight related to decreased activity level and debility as evidenced by body mass index (BMI) of 40.2. Nutrition interventions included dialysis with 1.2 liter fluid restriction. Nutrition goals were to comply with diet restrictions and fluid restrictions per recommendations. On 2/6/14 R116 was observed at 2:02 p.m. eating his lunch after returning from dialysis. R116 stated that dialysis run had gone well. R116's lunch included carrots, meat with gravy, potatoes, applesauce and water with his medicine. R116 also had 3 cups/mugs of fluids - consisting of milk, juice and coffee, each mug was at least ¾'s full (which was a total of 18 ounces of fluids). During an interview on 2/7/14 at 3:00 p.m. registered dietician (RD) stated that the cups R116 was using held 8 ounces of fluid. The RD stated that R116 should not have received all those fluids and that staff needed education. The meal tray cards indicated that R116 was on a fluid restriction diet of 1.2 liters and that R116 was to have 4 ounces of juice and 4 ounces of water for lunch which was a total of 8 ounces (however, R116 received twice the amount of fluids at this	2 830		

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2 830	Continued From page 10 meal.) The care plan dated 1/27/14 indicated R116 had a risk for fluid output exceeding intake and instructing staff that R116 currently was on a 1.2 liter fluid restriction daily. One of the interventions instructed staff to provide R116 to have a 1.2 liter fluid restriction. The care plan dated 2/4/12 indicated a problem of alteration in kidney function due to end stage renal disease evidenced by hemodialysis. Interventions instructed staff to provide a diet and fluid restrictions as ordered by physician. Encourage patient to follow nutritional and hydration program interventions. A care plan dated 2/4/14 indicated R116 had a potential for alteration in hydration related to: edema, end stage renal disease, fluid restriction. Interventions instructed staff to maintain fluid restriction per physician order. Provide diet, fluids, per physician orders. During an interview on 2/6/14 at 1:55 p.m. with nurse aide (NA)-C, she stated that staff give fluid to R116 following the tray cards. NA-C indicated that the nurses know how much to give R116 with medications. Registered nurse (RN)-A, during an interview on 2/6/14 at 1:59 p.m., stated that she was not aware that R116 was on a fluid restriction. RN-A stated that she did not have any order to check off intake of fluids for R116. During an interview with the RD on 2/6/14 at 2:33 p.m., RD stated that the fluid restriction of R116 is on the resident ' s dietary cards and is on his care plan. The RD confirmed that no staff was keeping track of R116 ' s fluid intake daily. During an interview with R116 on 2/6/14 at 7:35	2 830		

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2 830	Continued From page 11 a.m., the resident indicated he had dialysis three times a week. He did not recall if he took medicine before his dialysis. R116 stated that they don't want him to retain fluids so that is why he figures part of his weight is due to fluids. R116 stated that they (facility staff), took all his water away last night. Before last night they weren't so strict. R116 stated he understands why he is on a fluid restriction. The director of nursing (DON) during an interview on 2/6/14 at 2:48 p.m. indicated that she would expect the nurses to be monitoring R116's fluid intake. An undated policy titled Fluid Restriction had been provided and no instruction on who would monitor a resident's fluid intake while on a fluid restriction. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could ensure that resident's that have dialysis needs are provided the necessary services. An inservice on Dialysis could be given to all nursing staff. Random audits could be completed to ensure the staff were compliant. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director	2 895		

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2 895	Continued From page 12 of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a resident's range of motion or need for a restorative services and develop such a program for 1 of 1 resident (R135) identified with limited range of motion of upper extremities. Findings include: R135 lacked an assessment and development of range of motion services for upper extremity functional limitations. On 2/5/2014 at 10:53 a.m., R135's right hand and fingers were observed to be contracted. The resident had no brace or splint on the hand. On 2/7/2014 at 8:45 a.m., R135 was observed to be eating using the left hand. The right hand lay in the lap and in a fisted position. The resident was interviewed and indicated the right hand did not hurt and no pain. A quarterly Minimum Data Set (MDS) dated 11/19/2013 was reviewed. R135's cognitive status was identified as severely cognitively impaired with limited assist of one staff for most activities of daily living. Functional limitations were identified as nothing for upper or lower extremities. Quarterly MDS for 8/21/2013 identified cognitive impairment as moderate,	2 895		

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2 895	Continued From page 13 limited assist with activities of daily living and no functional limitations or impairment identified in the upper or lower extremities. Admission MDS data set dated 6/17/2013 identified the resident with moderate cognitive impairment, extensive assist of one staff for activities of daily living and no functional limitation or impairment in the upper or lower extremities. Also included admission on 5/17/13. R135's care plan with completed date of 11/29/2013 was reviewed. It identified a physical functioning deficit related to self-care impairment, and mobility impairment. The interventions addressed a restorative program for ambulation but did not address the right hand/finger contractures. No physician note since admission was evident in the medical record that would address the contracture of the right hand. However, on 12/13/2013, the physician ordered "mitts" that could be heated and used for comfort. On 2/6/2014 at 7:35 a.m., a nurse aide (NA)-E prepared R135's warm water to wash and set it on the Rollator walker seat. The resident was washing up using left hand with some assist from the right hand. NA-E stated the resident could do some things but it depended on the day and NA-E assisted the resident with the back and peri area. At 8:05 a.m. NA-E as interviewed regarding doing range of motion or doing any treatment to the resident's right hand. She stated she didn't do range of motion but at least once a shift she would put on the heated glove (light blue mitt) and stated it was heated up in the microwave. On 2/6/2014 at 12:45 p.m., NA-F stated she did not do anything with the resident's right hand	2 895		

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2 895	Continued From page 14 except wash it real good. She did not do range of motion or any kind of treatment such as the heated gloves. Social services (SS)-X was interviewed on 2/7/2014 at 9:10 a.m. regarding use of the heated gloves for R135. The SS-X indicated the family applied the heated gloves because the facility staff cannot do that here. The facility didn't do things with heat. She indicated physical therapy and occupational therapy seen the resident and should check with them. The family bought the heating gloves on their own and brought them in. On 2/7/2014 at 10:40 a.m. the occupational rehab director (ORD) provided information and stated the resident was not seen for a contracture of the right hand. The information did not identify the resident had a contracture of the right hand/fingers. On 2/7/2014 at 10:45 a.m., the assistant director of nursing (ADON) was interviewed. She stated the resident did not have a contracture of the right hand. The resident used that hand. I, the surveyor had not seen the resident use the right hand at all. We went up to the resident's room and asked the resident to open the right hand. The third, fourth and little finger, R135 could not straighten out. The resident indicated it didn't hurt. The resident did not have anything in the hand but it was a closed fist. The ADON had observed that with the surveyor. The ADON indicated she would call the OT rehab director, which she did. At 10:55 a.m., the ORD was informed about what the ADON and the surveyor observed and she indicated she would take a look at it. All nursing notes from admission through	2 895		

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2 895	Continued From page 15 2/7/2014 were reviewed. Nothing was documented as far as contractures of the right hand/fingers. On 2/7/2014 at 1:00 p.m., the ORD director was interviewed and stated she verified she did not find any documentation about the right hand/finger contracture. On 2/7/2014 at 2:50 p.m., NA-G had not noticed any problems with R135. NA-H seen the resident rubs hands and the resident could open the left hand but not the right hand. Registered nurse (RN)-A, thought that both hands were contracted but able to use cup and walk with walker and required limited assistance. RN- A indicated the resident's hands had been that way since she started in 5/2013. On 2/7/2014 at 2:55 p.m., R135's family (F)-A was interviewed regarding the resident's right hand/finger contractures. F-A stated R135 has had those for 5 years or so but had gotten worse in the last 3 years. R135 was admitted to the facility with the right hand like that. F-A thought physical therapy (PT) worked on that and it didn't help. But as a family, the only thing they found that helped was the heating mitts. She indicated the family put the mitts on when they visit because the facility stated they couldn't do it. The mitts seemed to help with the discomfort. Staff knew about R135 because they helped the family with the mitts. On 2/7/2014 at 3:00 p.m. the occupational rehab director (ORD) was interviewed on the assessment of range of motion for residents. She indicated nursing did the range of motion for the MDS. According to the ORD, the resident was discharged on 7/1/2013 from Occupation therapy services and she didn't ever remember seeing any issues with R135's right hand. They	2 895		

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2 895	Continued From page 16 (facility staff) would not do the gloves because they couldn't do continual monitoring but nurses could do it if they could monitor it. No one has approached her about evaluating the hand. On 2/7/2014 at 3:15 p.m., MDS coordinator/register nurse (RN)-B was interviewed regarding the assessment data for functional limitations being no limitations of upper and lower extremities. RN-B depended on nursing documentation and physical therapy documentation regarding the range of motion functional limitations for the MDS assessment. RN-B stated she looked at residents by passing them in the hallway but did not do a range of motion evaluation. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could ensure that resident's with functional limitations are identified and assessed on admission to the facility. Resident's identified with functional limitations are provided with a program and treatment to prevent further limitation and/or maintain the resident's abilities. The Director of Nursing could give education to the nursing staff regarding treatment of resident's with functional limitations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing	2 910		

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2 910	Continued From page 17 home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to provide necessary toileting services for 1 of 3 residents (R111) reviewed for incontinence; the facility failed to provide bladder treatments and services for 2 of 2 residents (R133, R139 who had indwelling urinary catheters. Findings include: R111 did not receive toileting services in accordance with the plan of care. Review of the quarterly Minimum Data Set (MDS) dated 1/14/14 indicated R111 had diagnoses that included Alzheimer's; was unable to participate in the brief interview of mental status (BIMS); had long and short term memory impairment; was frequently incontinent of bladder; and did not participate in a toileting program. On 2/5/14 at 9:20 a.m. R111 was noted to be lying fully dressed on back in bed. Odor of bowel movement (BM) was noted. On 2/6/14 at 8:30 a.m. R111 was receiving morning personal cares. The room had an odor of urine. Nursing assistant (NA)-B stated R111 was assisted to the chair	2 910		

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2 910	Continued From page 18 using a standing lift. NA-B stated the resident had been incontinent of urine this am. NA-B stated R111 would at times tell staff when needed to have a bowel movement, but not if need to void urine. NA-B stated staff did not put R111 on the toilet unless the resident asked. NA-B verified she had not toileted R111 when she got R111 up from bed. The care plan dated 10/24/13 was provided 2/7/14. The care plan identified a problem of urinary tract infections initiated 6/18/13. Approaches/interventions directed staff to assist resident with toileting or incontinence as needed. Toilet resident upon waking, before and after meals, prior to activities, before bed and every two hours during the night. A second care plan provided 2/7/14 and dated as printed 2/7/14 showed no changes. The nursing assistant worksheet provided 2/7/14 indicated R111 was to be toileted every two hours. Licensed practical nurse who was the clinical manager for third west wing was interviewed on 2/714 at 9:30 a.m. stated staff was to offer toileting every 2 hours. CATHETER CARE WAS NOT PROVIDED TO PREVENT URINARY TRACT INFECTIONS: R133 received personal cares and changing of catheter bags, but did not receive perineal care and did not receive care to prevent cross contamination. Urology physician note of 12/20/13 indicated a diagnosis of probably hypotonic (having less than normal tone) bladder with incomplete bladder emptying. During an interview on 2/4/14 at 1:00 p.m. the licensed practical nurse/clinical manager	2 910		

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2 910	Continued From page 19 (LPN/CM) of the third west unit stated R133 had an indwelling Foley catheter because of urine retention and inability to void. R133 was observed on 2/6/14 at 7:35 a.m. during morning cares. R133 ' s leg catheter bag was observed not to have a cap on the insertion port to protect it from infections. The bladder tubing was observed to be wrapped in a wash cloth that had been used by NA-A to wipe the residents face. The bladder tubing with wash cloth was then placed on the bed between the residents legs. NA-A was observed to continue dressing R133 without changing her soiled gloves and again without changing her gloves touch the bladder tubing to attach the tubing to the leg bag. In addition during the personal cares, no perineal care was provided to R133. At 7:45 a.m. NA-A stated the catheter bag tip cover was in the plastic bag in the bathroom. NA-B stated the catheter bag tip and catheter tip should have been wiped with an alcohol pad before attaching them. On 2/6/14 at 9:20 a.m. the LPN/CM on third floor west stated the bag and tubing were stored in a garbage bag and that there was a cap to be placed on the insertion port to protect the tubing. LPN/CM also stated alcohol wipes were to be used to cleanse the tubing and tips. On 2/16/14 at 2:50 p.m. the director of nursing was interviewed. She indicated the facility did not have a policy related to changing catheter bags. DON also stated the indwelling catheter policy did not direct care of the catheter and perineal care for residents with the indwelling catheter. DON stated she would expect perineal care to be completed once a shift for all residents with indwelling catheter.	2 910		

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2 910	Continued From page 20 R139 did not receive catheter care to prevent urinary tract infection with the use or a urinary catheter leg bag. R139's signed physician order sheet dated 1/14/14 indicated that diagnoses included acute, unspecified disorder of kidney and ureter also R139 was admitted on 6/27/13. R139 ' s quarterly Minimum Data Set dated 12/30/13 indicated R139 had a brief interview for mental status (BIMS) of 11 which was cognitively intact. R139 was independent with bed mobility, transfers, and ambulation. R139 was extensive assist with personal hygiene. Nurses notes dated 2/1/14 indicated resident was complaining of urgency to void but when attempting to void resident could only go small amounts. The nurse attempted to in/out catheterize resident but was unable, and met blockage of some type. Resident was sent to the emergency room. R139 returned to nursing home with a diagnosis of a urinary tract infection and was started on Cipro (antibiotic) 250 mg twice a day for 7 days and had a urinary catheter placed. On 2/6/14 at 7:45 a.m. R139 was in bed with head elevated and his knees bent. R139 had a urinary leg bag on his left lower leg which was higher than his bladder in this position. During an interview with a licensed practical nurse (LPN)-B on 2/6/14 at 11:15 a.m. she indicated that R139 is to be in bed with his legs straight. LPN-B did not know if the urinary bag had an anti-reflux on it (but was found later to not have an anti-reflux valve so the urine in the bag could flow back into the bladder if the urine bag was higher than the bladder.) She sated she instructed and reminds R139 and staff to elevate head of bed and make sure his legs are straight	2 910		

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2 910	Continued From page 21 to keep the urine bag lower than the bladder. During an interview with LPN-D on 2/6/14 at 11:15 a.m. she stated that they currently do not have leg bags that are anti-flow /reflux in their facility, however she was able to contact a supplier and they will be shipping out a case of them that would be delivered the following day. The Medline leg bag in the bag had no mention as to whether it prevents reflux. Nurses notes dated 2/5/14 indicates that R139 continues on an antibiotic, Cipro, for the treatment of a urinary tract infection. R139 is reminded when in bed to keep his legs straight and his head of bed elevated so the urine can drain properly into his leg bag. On 2/7/14 at 7:11 a.m. R139 was observed to be in bed with his clothes on and the head of the bed elevated with knees bent. The leg bag was observed to be on his left leg, above the knee. R139 ' s comprehensive care plan dated 2/1/14 indicated that there was an alteration in elimination of bladder related to an indwelling urinary catheter placed on 2/1/14 related to inability to void and unable to in and out catheterize related to resistance, history of urinary tract infections, and urinary retention. The goal would have R139 free of urinary tract infection, and would have no complications from use of indwelling catheter such as pain, infection, obstruction. Interventions included anchoring the catheter, avoiding excessive tugging on the catheter during transfer and deliver of care. The staff was instructed to check the catheter tubing for proper drainage and positioning and to keep the drainage bag of the catheter below the level of the bladder at all times. On 2/7/14 at 2:10 p.m., it was observed and	2 910		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 22 LPN-D confirmed that R139 was wearing a leg bag that was not an anti-reflux urinary leg bag, The director of nursing (DON) was informed of R139 ' s urine possibly draining back into the bladder when the urine bag was higher than the bladder and the DON was requested to provide a policy for the use of leg bags that were not anti-reflux but one was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or Designee could ensure resident toileting needs are met as assessed by educating all nursing staff on resident's with incontinence and resident's using urinary catheters. Random audits of incontinent residents could be done. Random observations of resident's with urinary catheters could be done to ensure proper services are provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications	21580		

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	00953	A. BUILDING: _____ B. WING _____	02/07/2014

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21580	Continued From page 23 were administered without error for 2 of 6 residents (R8 and R91) whose medication administration was observed during medication pass. Findings include. R8 was found to have Lidoderm patch left on the skin beyond the recommended physicians order. R8 had a physician's order for Lidoderm patch 5% apply to lower back topically every 12 hours for pain related to lumbago. Leave on for up to 12 hours in one 24 hour period. R8 had diagnoses outlined on the 1/19/14 discharge summary osteoporotic compression fracture with the back, dementia. Licensed practical nurse (LPN) - A was observed on 2/6/14 at 7:14 a.m. applying the Lidoderm patch to R8's back. R8 still had a patch on lower back dated 2/5/14. LPN-A stated patch had been applied the day before and not removed. The nurse practitioner (NP)-Z was interviewed on 2/6/13 at 8:49 a.m. NP stated she had been told that Lidoderm would have adverse effects to someone who had liver problems, but she was unsure of R8's medical issues. NP-Z stated the patch should have been removed after 12 hours. NP-Z provided a copy of Micromedix (Evidence-Based Resources) information related to Lidoderm. Per NP this is the information that she uses. Micromedix stated the drug would be excreted through the kidney and metabolized by the liver. The Micromedix indicated the patch was to be "applied to intact skin and remove patch after a maximum of 12 hours of application within a 24-hour period."	21580		

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21580	Continued From page 24 R91 had received Fluoxetine HCl 20 mg each day but had a physician ' s order for 30 mg per day and the wrong dose had been given for over a year without clarifying the order with the physician. Document review of signed physician orders dated 1/14/14; revealed orders for fluoxetine HCl 20 milligrams 1.5 tablets (30 milligrams) by mouth daily with order start date of 12/4/12 and R91 had a diagnosis of depression. During observation of the medication pass on 2/6/14, at 8:07 a.m., licensed practical nurse-C (LPN-C) administered fluoxetine, an antidepressant medication, and 20 milligrams by mouth to R91. During interview at that time, LPN-C verified the medication label was fluoxetine 20 milligrams (mg). Document review of physician orders revealed orders for fluoxetine 20 milligrams 1 ½ tablets, with start date of 12/4/12. Document review of the facility medication administration record (MAR) for 12/13, 1/14, and 2/14, revealed fluoxetine HCl (20 mg) 1.5 tab (30 mg) by mouth once daily with order date of 12/4/12. During interview on 2/6/14, at 1:54 p.m., LPN-C verified physician orders for fluoxetine 20 milligrams 1 ½ tablets. She verified the order start date was 12/4/12, a period of 14 months without the physician ordered 30 milligrams of antidepressant. Document review of facility policy Monthly Medication Review Guideline dated 1/11, read,	21580		

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21580	Continued From page 25 "Medication orders will be reconciled monthly prior to beginning use of the new monthly Medication Administration Records and Treatment Administration Records to ensure accuracy. This reconciliation will be a three way check system that compares the medical record to current and new medication administration records." 1. New Medication Administration Records (MAR) and Treatment Administration Records (TAR) are printed. 2. The current MAR and TAR is compared to the newly printed MAR and TAR to determine if all changes are reflected on the new MAR/TAR. 3. The physician order and progress note section of the medical record is reviewed for any changes to determine if there have been any orders not captured on the current and/or new MAR/TAR. Monitoring for Compliance-the nurse signs and dates physician order sheet to indicate reconciliation/review of medications. During interview on 2/7/14, at 2:13 p.m., interim director of nursing stated she expected staff to check medication orders and fix any discrepancies. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or pharmacist could in-service all employees responsible for medication administration to follow policies and proven standards of practice to safely administer medications to residents and prevent errors. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21580		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units	21670		

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21670	Continued From page 26 The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to provide adequate supply of bath linens to provide morning cares to residents on 3 west. This affects all 17 residents which included resident (R)-133 who needed towels for grooming. Findings include: R133 was observed during morning cares on 2/6/14 at 7:35 a.m. R133 had been observed to be washed and dried using two wash cloths. Nursing assistant (NA)-A stated the third floor did	21670		

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21670	Continued From page 27	21670		

not have cloth towels available so they used wash cloths in place of the towel. NA-B who was helping NA-A at the time said she could not find a hand towel for R133.

The linen closet was checked and observed on 3rd floor west at 8:08 a.m. and contained 1 bath towel, no hand towels, and 3 wash clothes.

On 2/6/14 at 8:12 a.m. social worker (SW)-Z was observed to bring a plastic bag containing 4 bath towel and hand towels to the unit.

On 2/5/14 at 1:30 p.m. laundry aid (LA)-A stated the nursing units do run out of linens sometimes.

On 2/6/14 at 9:20 a.m. licensed practical nurse/case manager of third floor west stated she was unaware of the lack of linen this morning for resident use. She continued to say that this has happened on other occasions and that a staff member should have called down to laundry to get more delivered.

On 2/6/14 at 9:30 a.m. the laundry director (LD) was interviewed and he indicated laundry staff arrive at 4:30 a.m. and do the laundry from the day before. LD continues to say that the laundry is taken to the floors between 9:00 a.m. and 9:30 a.m. LD indicated the facility had extra linen which was locked in the storage area.

On 2/6/14 at 2:50 p.m. the director of nursing stated she was not aware there had been a lack of linens for resident and staff use on the third floor east unit questioned staff concerning this issue.

SUGGESTED METHOD OF CORRECTION: The Laundry Director could ensure that all

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21670	Continued From page 28 resident areas had enough linens for daily care. Random audits of each area could be completed to check on supply of laundry and availability. A schedule could be developed to ensure all residents received enough laundry to complete daily cares. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21670		