CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0PEL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STA	IE STATE SURVEY AGENCY Facility ID: 00953			
1. MEDICARE/MEDICAID PROVIDER (L1) 245184 2.STATE VENDOR OR MEDICAID NO. (L2) 690925600	R NO.	3. NAME AND AL (L3) GOLDEN L (L4) 501 EIGHTI (L5) ROCHESTE	IVINGCENTE H AVENUE SO	R - ROCHI		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OV (L9) 05/12/2006	VNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	ORY 09 ESRD	<u>Q2</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 3/24/14 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	116 (L18)	Complian		S:	And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI	6. Scope of Services Limit 7. Medical Director		
13.Total Certified Beds	116 (L17)	B. Not in Co.	mpliance with Proents and/or Applie		5. Life Safety Code * Code: A	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOV	VN				15. FACILITY MEETS			
18 SNF 18/19 SNF 116 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)		
	review of the fac Please refer to the	cility's plan of co e CMS 2567B.	orrection, to v Effective Ma	erify that rch 19, 20	14, the facility is certified for 18. STATE SURVEY AGENCY	rtification Specialist 04/29/14		
P	ART II - TO BE	COMPLETED	BY HCFA R	(L19) EGIONA	L OFFICE OR SINGLE ST	ATE AGENCY		
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P. 2. Facility is not Eligible	YY articipate	20. COM	MPLIANCE WITH GHTS ACT:		21. 1. Statement of Final	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 09/01/1972 (L24)	BEGINNING (L41)		ENDING DA'		VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	INVOLUNTARY 05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
			(L45)					
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/0	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32. (L32)	04/03/2014	OF APPROVAL I	DATE (L33)	DETERMINATION APPR	OVAL		



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 B. Leach, Program Specialist

Colleen Feach

Program Assurance Unit

Licensing and Certification Program

cc: Licensing and Certification File



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, Program Specialist

Kumalu Fiske Downing

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245184	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/24/2014
Name	of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - ROCHESTER EAST			501 EIGHTH AVENUE SOUTHE	AST

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).

ROCHESTER, MN 55904

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	()	/ 5)	Date
ID Prefix Reg. # LSC	F0254 483.15(h)(3)		Correction Completed 03/19/2014	ID Prefix Reg. # LSC	F0258 483.15(h)(7)		Correction Completed 03/19/2014			F0278 483.20(g) - (j)		Correction Completed 03/19/2014
ID Prefix Reg. # LSC	F0280 483.20(d)(3), 4		Correction Completed 03/19/2014 2)	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 03/19/2014			F0285 483.20(m), 483		Correction Completed 03/19/2014
ID Prefix Reg. # LSC			Correction Completed 03/19/2014	ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 03/19/2014			F0318 483.25(e)(2)		Correction Completed 03/19/2014
	F0323 483.25(h)		Correction Completed 03/19/2014		F0425 483.60(a).(b)		Correction Completed 03/19/2014					
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC								
Reviewed E	By F	Reviewed	Ву	Date:	Signature	of Su	veyor:				Date:	
State Agen	•	GN/KF		04/02/20	014		101	60				03/24/2014
Reviewed E	By F	Reviewed	Ву	Date:	Signature	of Sui	veyor:				Date:	
Followup t	o Survey Com 2/7/20	•	1:		Check for any Uncorrected					Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

Ìde	ovider / Supplier / CLIA / entification Number	(Y2) Multiple Cons A. Building	struction 01 - MAIN BUILDING 01	(Y3) Date of Revisit 3/19/2014
245	5184	B. Wing		

Name of Facility

GOLDEN LIVINGCENTER - ROCHESTER EAST

Street Address, City, State, Zip Code

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	()	(5)	Date
		(Correction				Correction					Correction
ID Prefix			Completed 03/07/2014	ID Prefix			Completed 03/07/2014		ID Prefix			Completed
	NFPA 101				NFPA 101							
-	K0029			_	K0050				LSC			<u> </u>
		(Correction				Correction					Correction
ID D ('		(Completed	15.5 %			Completed					Completed
Reg. # LSC				Reg. # LSC					Reg. # LSC	_		<u> </u>
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ID Dog for		(Completed	ID Destin			Completed		ID Destin			Completed
												
Reg. # LSC				Reg. # LSC					Reg. # LSC	_		<u> </u>
		(Correction				Correction					Correction
ID Prefix		(Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #								
-									LSC			_
		(Correction				Correction					Correction
ID Prefix		(Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #					Reg. #			
				LSC								_
Reviewed I	By Re	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen	су	GS/KF	D	04/02/201	4		258	22				3/19/2014
Reviewed I	Ву Re	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
CMS RO												
Followup t	o Survey Comp		:		Check for any	Unco	rected Defi	cienci	ies. Was a	Summary of		
	2/5/201	14			Uncorrecte	a Defic	eiencies (CN	15-25	o/) Sent to	the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0PEL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PAR	AT I - TO BE COMPI	TELEDBYI	HE SIA	IE SURVEY AGENCY	F	acility ID: 00953
MEDICARE/MEDICAID PROVIDER NO. (L1) 245184 2.STATE VENDOR OR MEDICAID NO. (L2) 690925600	3. NAME AND AE (L3) GOLDEN L. (L4) 501 EIGHTI (L5) ROCHESTE	IVINGCENTE H AVENUE SC	R - ROC		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	N: <u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 05/12/2006			ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other
6. DATE OF SURVEY 02/07/2014 (L 8. ACCREDITATION STATUS: (L) 0 Unaccredited	34) 02 SNF/NF/Dual (0) 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDIN	G DATE: (L35)
	Compliance 1. Ac B. Not in Com		ram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B	6. Scope of Serv7. Medical Dire	vices Limit
116	SNF ICF .39) (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF AP	PLICABLE SHOW LTC CA	NCELLATION I	DATE):			
See Attached Remarks						
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Jennifer Lageson, HFE NE II	3	/19/2014	(L19)	K <u>amala Fiske-Downing, l</u>	Enforcement Specia	<u>alis</u> t 4/3/2014 (L20
PART II - TO	BE COMPLETED F	BY HCFA RE	GIONAL	L OFFICE OR SINGLE S	TATE AGENCY	`
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible		IPLIANCE WITH	I CIVIL	21. 1. Statement of Fina2. Ownership/Contro3. Both of the Above	ol Interest Disclosure Stmt (*
OF PARTICIPATION BEGIN 09/01/1972	GREEMENT 24 NNING DATE	I. LTC AGREEM ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse	INVOLUN' 05-Fail to M	L30) TARY Ieet Health/Safety Ieet Agreement
A. Sus	RNATIVE SANCTIONS pension of Admissions: cind Suspension Date:	(L25) (L44) (L45)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u>	· Status Change
28. TERMINATION DATE:	29. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	OF APPROVAL	DATE			
(L32)			(L33)	DETERMINATION APPI	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

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.



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:

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

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

Golden Livingcenter - Rochester East March 6, 2014 Page 2

<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.

Golden Livingcenter - Rochester East March 6, 2014 Page 4

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

Golden Livingcenter - Rochester East March 6, 2014 Page 5 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

Golden Livingcenter - Rochester East March 6, 2014 Page 6 Feel free to contact me if you have questions.

Sincerely,

Kumalu 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

PRINTED: 03/06/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE MARTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING MN Dept of Health Rochester B. WING 245184 02/07/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Submission of this Response and F 000 INITIAL COMMENTS F 000 Plan of Correction is not a legal admission that a deficiency exists or The facility's plan of correction (POC) will serve that this Statement of Deficiency as your allegation of compliance upon the was correctly cited, and is also not Department's acceptance. Your signature at the to be construed as an admission of bottom of the first page of the CMS-2567 form will fault by the facility, the Executive be used as verification of compliance. Director or any employees, agents or other individuals who draft or may Upon receipt of an acceptable POC an on-site be discussed in this Response and revisit of your facility may be conducted to Plan of Correction. In addition, validate that substantial compliance with the preparation and submission of this regulations has been attained in accordance with Plan of Correction does not vour verification. admission an constitute agreement of any kind by the facility of the truth of any facts alleged or A complaint investigation/s had been completed the correctness of any conclusions at the time of the standard recertification survey. set forth in the allegations. Investigation/s of complaint H184074 had been completed and had been substantiated. Facility the Accordingly. Deficiency/s had been issued as a result of the prepared and submitted this Plan of substantiated findings at F254. Correction prior to the resolution of any appeal which may be filed A standard recertification survey was conducted solely because of the requirements and a complaint investigation(s) had also been under state and federal law that completed at the time of the standard survey. An mandate submission of a Plan of investigation of complaint H5184077 had not Correction within ten (10) days of been substantiated during this survey. the survey as a condition to F 254 483.15(h)(3) CLEAN BED/BATH LINENS IN participate in Title 18 and Title 19 **GOOD CONDITION** SS=D programs. This plan of Correction is submitted as the facility's credible The facility must provide clean bed and bath allegation of compliance. 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. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING __ **COMPLETED** MAR 1 4 2014 245184 B. WING MN Dept of Health 02/07/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS COST STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) The facility will provide and have F 254 Continued From page 1 F 254 available clean linens for the 17 3-19-14 This affects all 17 residents which included residents affected and including resident (R)-133 who needed towels for Resident R133. grooming. The facility will provide and have Findings include: available clean/adequate linen for all residents R133 was observed during morning cares on 2/6/14 at 7:35 a.m. R133 had been observed to All nursing staff have been educated be washed and dried using two wash cloths. on the process of ensuring linens Nursing assistant (NA)-A stated the third floor did are available. Inservices were not have cloth towels available so they used wash completed on February 19 and 20, cloths in place of the towel. NA-B who was 2014. Inservices were completed helping NA-A at the time said she could not find a by the DNS and DCE. All hand towel for R133. environmental services staff have been inserviced by the The linen closet was checked and observed on **Environmental Services Manager on** 3rd floor west at 8:08 a.m. and contained 1 bath proper linen quantities and stocking towel, no hand towels, and 3 wash clothes. needs. On 2/6/14 at 8:12 a.m. social worker (SW)-Z was Weekly audits will be conducted observed to bring a plastic bag containing 4 bath once a week x 4 weeks and then towel and hand towels to the unit once a month x 3 months and as needed to monitor compliance of On 2/5/14 at 1:30 p.m. laundry aid (LA)-A stated adequate linens. the nursing units do run out of linens sometimes. Audit results will be reviewed during On 2/6/14 at 9:20 a.m. licensed practical provide process to QAA nurse/case manager of third floor west stated she redirection when or change was unaware of the lack of linen this morning for necessary and dictate continuation resident use. She continued to say that this has or completion of this monitoring happened on other occasions and that a staff process based on compliance. member should have called down to laundry to get more delivered. Executive Director is the responsible party On 2/6/14 at 9:30 a.m. the laundry director (LD) was interviewed and he indicated laundry staff Corrective Action will be completed arrive at 4:30 a.m. and do the laundry from the by March 19th, 2014 day before. LD continues to say that the laundry is taken to the floors between 9:00 a.m. and 9:30

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	DING 2014	(X3) DATE SURVEY COMPLETED
		245184	B. WING	MN Dept of Health Rochester	02/07/2044
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/07/2014
GOLDE	N LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE COMPLETION
SS=D	a.m. LD indicated the which was locked in On 2/6/14 at 2:50 pustated she was not a of linens for resident floor east unit quest issue. 483.15(h)(7) MAINT COMFORTABLE So The facility must procomfortable sound line for the facility must procomfortable sound line. This REQUIREMENT by: Based on observatification of 12 residents (R58 floor. Findings include: R8 noise loud enough to R58 was interviewed and stated the facility even with the room of interview on 2/6/14, a hallway was noisy at squeaky shoes worn.	the facility had extra linen the storage area. m. the director of nursing aware there had been a lack than a staff use on the third ioned staff concerning this send to the staff concerning this expected by the staff concerning this send to the maintenance of exels. This not met as evidenced on and interview, the facility expected for the sound levels for 2 to the staff complaints of facility expected for the maintenance of exels. The staff concerning this expected for the maintenance of exels. The staff concerning the staff concerning the night. The staff concerning the staff concerning the night with rolling carts and the staff concerning the sta	F 25	The facility will provide for maintenance of comfortable soulevels for the two residents affectory changing the vacuum schedules to a later time in morning. All wheels on carts will evaluated for opportunities reduncise levels. This evaluation will completed by March 4, 2014. residents have the potential to affected. The facility will provide for maintenance of comfortable no levels for all residents by changing the vacuuming schedules to a latime in the morning. This wacompleted on February 28, 2014. All staff will be in serviced on the importance of maintaining noi levels. Housekeeping staff will be serviced on maintaining noi levels. Education was completed through inservice meetings held February 19 and 20. The education	and sted sing the be ace be All be sise sing ster as the sise sing ster as the sise sing sise sied on son son sing ster as the sise sing sing sing sing sing sing sing sing
		d on 2/4/14, at 2:45 p.m., vacuumed the hallway		was completed by the DCE a DNS.	nd ·

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE			X3) DATE COMPI	
		245184	B. WING		MAR 1 4 2014	02/07	7/2014
	PROVIDER OR SUPPLIER N LIVINGCENTER - RO	OCHESTER EAST		501	REET ADDRES (NO PROSTATE BELLE IP CODE Rochester 1 EIGHTH AVENUE SOUTHEAST DCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 258	floors at 7:00 a.m., wakes everyone up the vacuum noise to not change the schevacuum early to wa During observations housekeeper (H)-A length of the hallwa During interview at been aware a reside early vacuum noise	ge 3 with room door open and R117 stated had reported o staff and was told they could edule. R117 said maybe they ke everyone up for the day. s on 2/6/14, at 6:54 a.m., was observed vacuuming the y that included R117's room. that time, H-A stated they had ent had complained about but was instructed to vacuum	F2	258	Weekly Audits will be conducted every week x 4 weeks and once month x 3 months to month compliance of noise levels in facily and the QAA process to proving redirection or change who necessary and dictate continuation completion of this monitor process based on compliance. Executive Director is the responsing party	e a itor lity. ring vide hen tion ring	
F 278 SS=D	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. 483.20(g) - (j) ASSESSMENT		F 2	78	Corrective Action will be comple by March 19th, 2014 F278		3-19-14
33-0		DINATION/CERTIFIED ust accurately reflect the			Resident R135 assessment accurately reflect the resident range of motion status.	1	
	each assessment w participation of healt	th professionals. The professionals in the state of the professionals.			All residents will be assessed will accurately reflect the residerange of motion status. Assessn of all residents in facility completed on February 7, 8, an 2014.	ents nent was	• • • • • • • • • • • • • • • • • • • •
	assessment must si that portion of the as Under Medicare and willfully and knowing	completes a portion of the gn and certify the accuracy of esessment. I Medicaid, an individual who ly certifies a material and resident assessment is			All nursing staff have been education the requirement to accurate identify and accurately assess rate of motion status. Insert education was completed February 19 and 20, 20 Education was provided by the Education and DCE.	ately ange rvice on 014.	1 (2) (1) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245184	B. WING		MAR 1 4 2014	02/	07/2014
	PROVIDER OR SUPPLIER			50	REET ADDRESS, COMPRESSER Rochester 1 EIGHTH AVENUE SOUTHEAST DCHESTER, MN 55904		
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F 278	subject to a civil m \$1,000 for each as willfully and knowir to certify a materiar resident assessment penalty of not more assessment. Clinical disagreem material and false This REQUIREME by: Based on interview facility failed to accompate Set (MDS) as (R135) reviewed with right hand/finger Findings include: contractures and with However, was obstingers on the right A quarterly Minimu 11/19/2013 was rewas identified as sowith limited assist of daily living. Fundentified as nothin extremities. Quarticely distributed assist with a functional limitation the upper or lower dated 6/17/2013 id cognitive impairmed	oney penalty of not more than sessment; or an individual who agly causes another individual I and false statement in a ent is subject to a civil money e than \$5,000 for each ent does not constitute a statement. NT is not met as evidenced w and document review, the curately code the Minimum is essment for 1 of 1 residents ho had visible contractures of ers. R135 was not identified with was not provided services. erved with contracture of 3	F 2	78		ange itted a d ange vide vhen ation oring sible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN	l'	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	MN Dept of Health	02/07/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 紫色市底层户 CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
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F 278	limitation or impair extremities. Also 5/17/2013 with dia failure, hypertensic pneumonia. On 2/7/2014 at 3: coordinator/registe interviewed regard functional limitatio having no limitatio extremities). RN-I nursing document documentation registe functional limit RN-B stated she le	rment in the upper or lower had been admitted on gnoses which included: heart on, dementia, and bacterial l.5 p.m., MDS ered nurse (RN)-B was ling the assessment data for ns for R135 (identified as ns of upper and lower attended on attended to a stated she depended on attended to complete the MDS. booked at residents by passing y but did not do a range of	F 27	Resident R133's catheter has to discontinued. Resident R133's plan has been revised to include toileting care. All residents have potential of being affected.	care lude the with and 014. ated ated were uary	
F 280 SS=D	PARTICIPATE PLATE	ANNING CARE-REVISE CP the right, unless adjudged nerwise found to be er the laws of the State, to ning care and treatment or and treatment. Care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility and other appropriate staff in rmined by the resident's needs, practicable, the participation of esident's family or the resident's e; and periodically reviewed eam of qualified persons after	F 280	Conducted the education. Weekly audits will be conducted once a week x4 weeks, then one month for 3 months, then as new thereafter to monitor compliance. Audit results will be reviewed do the QAA process to process.	cted ce a eded during ovide vhen ation oring	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		245184	B. WING			02	/07/2014
	PROVIDER OR SUPPLIER I LIVINGCENTER - RO	OCHESTER EAST		50	REET ADDRESS, CITY, STATE, ZIP CODE 11 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa each assessment.	ge 6	F 2	80			
	by: Based on observat review, the facility fa in regards to direct:	NT is not met as evidenced ion, interview and document ailed to revise the plan of care staff related to catheter care (R133) reviewed with					
	catheter but lacked direct staff related to	133 had an indwelling Foley the revision of the catheter to personal cares. ote of 12/20/13 indicated					
	R133 had a diagnos	sis of probable hypotonic adder with incomplete bladder					
	morning cares. Nur replaced the Foley of leg bag and then dre assisted R133 to wa perineal cares which	on 2/6/14 at 7:35 a.m. during sing assistant (NA)-A catheter bedside bag with a essed the resident. NA-A ash face, but did not provide a should include catheter nt urinary tract infections and er.					
	identified as self-car toileting assistance. infection was identifi directed: 1) assist wi care 2) catheter leg weekly 3) change Fo	d 2/7/14 had a problem e impairment that directed A problem of urinary tract ed. The interventions ith toileting or incontinence and bedside bag changed bley catheter every month. 4) atheter care every shift and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245184	B. WING		0.	2/07/2014	
	PROVIDER OR SUPPLIER N LIVINGCENTER - RO			STREET ADDRESS, CITY, STATE, ZIP (501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 280		nge 7 catheter and tubing	F 28	F282	; ;	3-19-14	
	appropriately. The maintain aseptic te	care plan did not direct staff to chnique while working with t direct staff to provide		R139 catheter was remore has discharged from the home. All residents with catheters have the peing affected.	e facility to indwelling		
	indicated R133 had staff related to care cares, or changing On 2/6/14 at 2:50 p	ant worksheet provided 2/7/14 a catheter, but did not direct of the catheter, perineal the catheter bag. .m. Director of nursing did not have a policy to direct		All residents care p catheters will be revi- revised if needed in regar care staff related to cat All will be reviewed and March 9, 2014.	ds to direct heter care.		
	staff on catheter cal bedside bags, or pro she felt that perineal every shift.	re, changing urine leg and oviding perineal cares. Also all cares should be provided	F 28	All nursing staff have bee on care plans and cath Inservices were completed and 20, 2 Education was completed DCE and DNS.	neter care. oleted on 014. The	. 45	
	must be provided by accordance with eac care.	ed or arranged by the facility y qualified persons in ch resident's written plan of		Weekly audits will be concare plans once a week then once a month x 3 nas needed thereafter compliance.	x4 weeks, nonths and		
	by: Based upon observ document review, th use of a leg bag acc 1 of 1 residents (R13 indwelling catheter.	ation, interview, and se facility failed to provide the cording to the plan of care for (39) reviewed with an (39 was observed to have the		Audit results will be reviet the QAA process to redirection or change necessary and dictate cor completion of this process based on compliant.	provide ge when ontinuation monitoring ance.		
	urine bag higher tha the urine to drain ba- increases the chance	n the bladder which allows ck into the bladder which e of getting a urinary tract are plan for having the urine		DNS or designee is the r party. Corrective Action will be by March 19th, 2014	·		

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		245184	B. WING		n:	2/07/2014	
	PROVIDER OR SUPPLIER I LIVINGCENTER - RO	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIF 501 EIGHTH AVENUE SOUTHEAS ROCHESTER, MN 55904	PCODE	2/0//2014	
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	bag below the level provided by staff. On 2/6/14 at 7:45 a head elevated and lurinary leg bag on head was higher than On 2/7/14 at 7:11 a. in bed with his cloth elevated with knees observed to be on hand again put the urbicensed practical norom to check on renursing assistant shathe catheter tubing. urine bag to be placereduce the chance of bladder. R139's care plan detection, and would and out catheterize rof urinary tract infect The goal would have infection, and would use of indwelling catheter, avoiding excatheter, avoiding excatheter, avoiding excatheter during transistaff was instructed to for proper drainage as the drainage bag of the bladder at all tick.	of the bladder had not been m. R139 was in bed with his knees bent. R139 had a is left lower leg and the urine in the bladder at this time. m. R139 was observed to be seen on and the head of the bed bent. The leg bag was is left leg, above the knee ine bag above the bladder. urse (LPN)-B came into the sident and stated that the ould have put an extender on The extender would allow the ed lower than the bladder and if urine draining back into the lated 2/1/14 indicated that on in elimination of bladder ng urinary catheter placed on bility to void and unable to in elated to resistance, history ions, and urinary retention. R139 free of urinary tract have no complications from meter such as pain, infection, ations included anchoring the cessive tugging on the fer and deliver of care. The ocheck the catheter tubing and positioning and to keep the catheter below the level	F 2	32			
C	disorder of kidney an	d ureter.				: -	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245184	B. WING		02/07/2	014
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE COM	(X5) IPLETION DATE
	On 2/7/14 at 2:10 p LPN-D confirmed th bag that was not ar The director of nurse concern with R139 directed in the com had been asked to who use an indwelli treatment. None had 483.20(m), 483.20(FOR MI & MR A facility must coord pre-admission scre program under Med the maximum exter duplicative testing at A nursing facility mu January 1, 1989, ar (i) Mental illness a (i) of this section, un authority has deterr independent physic performed by a pers State mental health (A) That, becaus condition of the indi the level of services and (B) If the individu services, whether th specialized services (ii) Mental retardat (m)(2)(ii) of this section (m)(2)(iii) of this section (m)	.m., it was observed and nat R139 was wearing a leg nanti-reflux urinary leg bag. Sing was informed of the not receiving cares as prehensive care plan and also provide a policy for residents ing catheter and care and disen provided. e) PASRR REQUIREMENTS dinate assessments with the ening and resident review dicaid in part 483, subpart C to not practicable to avoid and effort. Just not admit, on or after may new residents with: sing defined in paragraph (m)(2) ness the State mental health mined, based on an all and mental evaluation son or entity other than the authority, prior to admission; so of the physical and mental vidual, the individual requires is provided by a nursing facility; all requires such level of the individual requires of the individual requires of the individual requires as for mental retardation. John State mental opmental disability authority authority authority	F 2	Resident R101 preadmi screening was obtained but placed on the PASSR form. preadmission is in the chart February 8, 2014. All residents to be affected All residents with a mental in diagnosis will have a preadmission.	ssion Interpretation	-19-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			MAR 1 4 201	(X3) D/	COMPLETED	
		245184	B. WING			MN Dept of Hand	١ ٨	2/07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		501 I	EET ADDRESS, CIT EIGHTH AVENUE CHESTER, MN	ry, statë, zip code E southeast			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORF	R'S PLAN OF CORRE RECTIVE ACTION SHO RENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 285	(A) That, because condition of the independent of the individual is illness" if the individual is illness defined at § (ii) An individual is retarded" if the individual is retarded" if the individual is retarded in §483.10 related condition as This REQUIREME by: Based on interview facility failed to ensempleted for 1 of admitted with a mediated with a mediated preadmission determine what mediated included bipolar disdisorder according List and according the services and included bipolar disdisorder according List and according the services and included bipolar disdisorder according List and according the services and included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according List and according the services and the included bipolar disdisorder according	see of the physical and mental ividual, the individual requires is provided by a nursing facility; all requires such level of the individual requires is for mental retardation. It is section: It is considered to have "mental dual has a serious mental 483.102(b)(1). It is considered to be "mentally vidual is mentally retarded as 2(b)(3) or is a person with a section described in 42 CFR 1009. In it is not met as evidenced and document review, the sure preadmission screening 1 resident (R101) who was antal illness diagnosis. In it is not met as evidenced to ental illness diagnosis without sion screening completed to ental illness services they may a 6/16/11, with diagnosis that sorder and schizoaffective to facility Medical Diagnosis to the facility Admission	F 2	285					
		ed R101 on the quarterly (MDS), an assessment dated						4.	

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		245184	B. WING _		02	2/07/2014		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	depression and sol antipsychotic and, antipsychotic and, antipsychotic and, antipsychotic and, alteration in mood, psychotropic medic services, interventioneeded. Care plan staff R101 was at rinterventions include psychologist/psychologist	liagnosis that included manic nizophrenia, received antidepressant medication. of resident care plan initiated staff R101 was at risk for currently received cations and mental health ons included psych services as initiated 11/28/11, directed isk for alteration in behaviors, led refer to liatrist as needed. of facility Psychotropic Dose dated 1/2/14; revealed R101 by psychology and psychiatry of facility Psychosocial rterly dated 12/30/13, revealed ods, was involved with mental didagnosis of schizoaffective 2/6/14, at 11:40 a.m., the ursing verified the facility dimission screening for R101. that time, social services rocedure was that the hospital ssion screening and then a enhospital to the county to	F 28	5				
	which identified plar	n: #3. "Anticipate that Golden admit after the level 2						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING MAR 1 4 2014	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	MN Dept of Health	02/07/2014	
	PROVIDER OR SUPPLIER N LIVINGCENTER - R	OCHESTER EAST		STREET ADDRESS, CITPOSTAPE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
·	verified the facility I screening complete called the county not 483.25 PROVIDE (HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psychological screening complete.	a 2/7/14, at 8:55 a.m., SS-A acked evidence of level 2 ed. SS-A stated she had just ow to obtain level 2 screening. CARE/SERVICES FOR	F 2	F309 Resident R116 fluid restrictions be monitored according to physic orders. All residents have	cted cted ce a eded	
	by: Based on observat documentation, the stage renal disease the health needs of received dialysis se Findings include: R of 1.2 liters (approx per day) however, t system in place to ic dietary and nursing keep fluid intake to keeping a record of R116 was maintaini day. Physician orders da resident was to hav fluid restriction was	NT is not met as evidenced cion, interview and facility failed to provide end care and treatments to meet 1 of 1 resident (R116) who rvices due to renal failure. R116 was on a fluid restriction imately 5 eight ounce cups he facility did not have a dentify how much fluids would give R116 each day to 1.2 liters nor was anyone the fluid intake to determine if ng no more than 1.2 liters per ted 1/31/14 instructed e a dialysis diet with a 1.2 liter admitted on 1/16/14 and had stage renal disease (ESRD)		Audit results will be reviewed du the QAA process to pro- redirection or change vi- necessary and dictate continu- or completion of this monito- process based on compliance. DNS or designee is the respon- party. Corrective Action will be comp- by March 19th, 2014	ovide when ation oring nsible	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245184	B. WING		02	2/07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STAT 501 EIGHTH AVENUE SOUT ROCHESTER, MN 55904	E, ZIP CODE HEAST	:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	and now dialysis dechronic atrial fibrilla R116 admission Minassessment of need that R116's brief int (BIMS) was 15 which Also the MDS assessupervision with beand corridor, dressing with personal hygies. The nutrition assess that R116 was over activity level and demass index (BMI) of included dialysis with Nutrition goals were restrictions and fluid recommendations. On 2/6/14 R116 was his lunch after return stated that dialysis in lunch included carroapplesauce and was also had 3 cups/mulmilk, juice and coffe full (which was a tot During an interview registered dietician R116 was using held stated that R116 shot those fluids and that meal tray cards indicrestriction diet of 1.2 have 4 ounces of juil lunch which was a tot lunch which was a tot have 4 ounces of juil lunch which was a tot lunch which was a tot have 4 ounces of juil lunch which was a tot lunch which was a tot lunch which was a tot have 4 ounces of juil lunch which was a tot lunch which was a	ependent, hypertension, tion. nimum Data Set (an ds) dated 1/23/14 indicated erview for mental status ch indicated cognitively intact. ssment showed R116 needed d mobility, walking in room ng, eating and independent ne. sment dated 1/16/14 indicated weight related to decreased bility as evidenced by body f 40.2. Nutrition interventions th 1.2 liter fluid restriction.	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245184	B. WING _		02	/07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP 501 EIGHTH AVENUE SOUTHEAS ROCHESTER, MN 55904	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	The care plan dated a risk for fluid output instructing staff that liter fluid restriction instructed staff to p fluid restriction. The indicated a problem function due to end evidenced by hemorinstructed staff to prestrictions as order patient to follow nut interventions. A car R116 had a potential related to: edema, restriction. Interventional intervention interven	d 1/27/14 indicated R116 had at exceeding intake and t R116 currently was on a 1.2 daily. One of the interventions rovide R116 to have a 1.2 liter e care plan dated 2/4/12 of alteration in kidney stage renal disease dialysis. Interventions rovide a diet and fluid red by physician. Encourage ritional and hydration program re plan dated 2/4/14 indicated al for alteration in hydration end stage renal disease, fluid ations instructed staff to etion per physician order. per physician orders. on 2/6/14 at 1:55 p.m. with she stated that staff give fluid e tray cards. NA-C indicated w how much to give R116 with RN)-A, during an interview on stated that she was not s on a fluid restriction. RN-A not have any order to check	F 30	9			
	p.m., RD stated that on the resident 's d plan. The RD confir keeping track of R1	with the RD on 2/6/14 at 2:33 at the fluid restriction of R116 is letary cards and is on his care med that no staff was 16 's fluid intake daily.				.:	
	During an interview	with R116 on 2/6/14 at 7:35					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		245184	B. WING		02/07/2014
	PROVIDER OR SUPPLIER N LIVINGCENTER - R	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY)	D BE COMPLETION
	a.m., the resident in times a week. He medicine before his they don't want him he figures part of h stated that they (far away last night. Be strict. R116 stated fluid restriction. The director of nurs on 2/6/14 at 2:48 p. expect the nurses to intake. An undated policy to been provided and monitor a resident's restriction.	indicated he had dialysis three did not recall if he took is dialysis. R116 stated that is or retain fluids so that is why is weight is due to fluids. R116 cility staff), took all his water after last night they weren't so he understands why he is on a sing (DON) during an interview in indicated that she would to be monitoring R116's fluid steed Fluid Restriction had no instruction on who would is fluid intake while on a fluid HETER, PREVENT UTI,	F 3	Resident R111 will receive to services per care plan. Re R133 catheter has been rem Resident R139 is no longer facility, catheter was rer before discharge from facility. All residents have the potentia affected. All residents will receive toileting care plan. All residents indwelling catheters will resideder treatments and service care plan.	sident noved. in the noved to be ing per with eceive
	assessment, the factoresident who enters indwelling catheter in resident's clinical control catheterization was who is incontinent of treatment and servicinfections and to residention as possible this REQUIREMENT by: Based on observations and the factor in the resident	ent's comprehensive cility must ensure that a the facility without and is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate cases to prevent urinary tract entered as much normal bladder on interview and document ailed to provide necessary		•	ce. during rovide when uation toring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245184	B. WING			02/	07/2014
	PROVIDER OR SUPPLIER			50 ⁻	REET ADDRESS, CITY, STATE, ZIP CODE 1 EIGHTH AVENUE SOUTHEAST DCHESTER, MN 55904		;
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	toileting services for reviewed for incont provide bladder tre residents (R133, R catheters.	or 1 of 3 residents (R111) cinence; the facility failed to atments and services for 2 of 2 139 who had indwelling urinary	F 3	15			
	Review of the quar dated 1/14/14 indic included Alzheimer the brief interview of long and short term	ance with the plan of care. Iterly Minimum Data Set (MDS) Eated R111 had diagnoses that Iters; was unable to participate in of mental status (BIMS); had n memory impairment; was ent of bladder; and did not eting program.					77 77
	lying fully dressed of movement (BM) wat a.m. R111 was record the room had an of (NA)-B stated R111 using a standing lift had been incontine stated R111 would to have a bowel mourine. NA-B stated toilet unless the results.	a.m. R111 was noted to be on back in bed. Odor of bowel as noted. On 2/6/14 at 8:30 eiving morning personal cares. It was assisted to the chair to the thing to the chair to furine this am. NA-B at times tell staff when needed overment, but not if need to void staff did not put R111 on the sident asked. NA-B verified she 11 when she got R111 up from					
	2/7/14. The care p urinary tract infection Approaches/interver resident with toiletin Toilet resident upon	d 10/24/13 was provided lan identified a problem of ons initiated 6/18/13. entions directed staff to assisting or incontinence as needed. In waking, before and after vities, before bed and every					12 12 12 12 12 12 12 12 12 12 12 12 12 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			(X3) DATE SURVEY COMPLETED		
		245184	B. WING			02/07/2014		
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP CO 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	two hours during the provided 2/7/14 and showed no change worksheet provided be toileted every two Licensed practical manager for third wo 2/714 at 9:30 a.m. stoileting every 2 hours CATHETER CARE PREVENT URINAF	e night. A second care plan d dated as printed 2/7/14 s. The nursing assistant d 2/7/14 indicated R111 was to to hours. The nurse who was the clinical west wing was interviewed on stated staff was to offer	F3	15				
	diagnosis of probab normal tone) bladde emptying. During a p.m. the licensed pr (LPN/CM) of the thi	ote of 12/20/13 indicated a ply hypotonic (having less than er with incomplete bladder in interview on 2/4/14 at 1:00 ractical nurse/clinical manager in west unit stated R133 had catheter because of urine ty to void.						
	morning cares. R13 observed not to have to protect it from information was observed to be had been used by Nace. The bladder to then placed on the I legs. NA-A was observed.	I on 2/6/14 at 7:35 a.m. during 3's leg catheter bag was to a cap on the insertion port ections. The bladder tubing wrapped in a wash cloth that IA-A to wipe the residents ubing with wash cloth was bed between the residents served to continue dressing ling her gloves touch the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245184	B. WING			02	/07/2014
İ	PROVIDER OR SUPPLIER I LIVINGCENTER - RO	OCHESTER EAST		501	EET ADDRESS, CITY, STATE, ZIP CODE EIGHTH AVENUE SOUTHEAST CHESTER, MN 55904	, 02	70172014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	bladder tubing to att In addition during th care was provided the stated the catheter In plastic bag in the back catheter bag in the back catheter bag tip and been wiped with an them. On 2/6/14 at 9:20 at west stated the bag garbage bag and the placed on the insert LPN/CM also stated used to cleanse the Unit of the care of the for residents with the stated she would explain the completed once a strindwelling catheter. R139 did not receive urinary tract infection catheter leg bag. R139's signed physically signe	e personal cares, no perineal o R133. At 7:45 a.m. NA-A pag tip cover was in the atthroom. NA-B stated the catheter tip should have alcohol pad before attaching m. the LPN/CM on third floor and tubing were stored in a set there was a cap to be son port to protect the tubing. alcohol wipes were to be tubing and tips. b.m. the director of nursing the indicated the facility did not a to changing catheter bags. Indwelling catheter policy did to changing catheter bags. Indwelling catheter. DON poect perineal care to be set indicated the facility did not be catheter and perineal care to be set indwelling catheter. DON poect perineal care to be set indicated the facility with the use or a urinary catheter care to prevent the with the use or a urinary con of 6/27/13. Inimum Data Set dated and 139 had a brief interview for of 11 which was cognitively lependent with bed mobility, ation. R139 was extensive mygiene.	F3	15			
1 .	vuises notes dated 2	2/1/14 indicated resident was				1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
		245184	B. WING			02/	07/2014	
1	OF PROVIDER OR SUPPLIER DEN LIVINGCENTER - RO	OCHESTER EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904					
(X4) PRE TA	FIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F3	attempting to void ramounts. The nurse catheterize resident blockage of some the emergency room. It home with a diagnorand was started on twice a day for 7 dat placed. On 2/6/14 at 7:45 at head elevated and urinary leg bag on higher than his blade. During an interview nurse (LPN)-B on 2 indicated that R139 straight. LPN-B did had an anti-reflux of have an interview and the instructed and remit head of bed and matto keep the urine batto the u	ency to void but when resident could only go small be attempted to in/out to but was unable, and met appe. Resident was sent to the R139 returned to nursing resis of a urinary tract infection (Cipro (antibiotic) 250 mg resident was in bed with the sent of the R139 was in bed with the sent of the R139 was in bed with the sent of the resident of the	F 3	15				
	continues on an anti							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245184	B. WING			02/	07/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	reminded when in band his head of beddrain properly into hon 2/7/14 at 7:11 a in bed with his cloth elevated with kneed observed to be on hR139's compreher indicated that there elimination of bladd urinary catheter planinability to void and catheterize related that tract infections, and would have R139 frand would have no indwelling catheter obstruction. Intervecatheter, avoiding ecatheter during transtaff was instructed for proper drainage the drainage bag of of the bladder at all	bed to keep his legs straight delevated so the urine cannis leg bag. I.m. R139 was observed to be less on and the head of the bed less bent. The leg bag was his left leg, above the knee. Insive care plan dated 2/1/14 was an alteration in er related to an indwelling ced on 2/1/14 related to unable to in and out to resistance, history of urinary diurinary retention. The goal lee of urinary tract infection, complications from use of such as pain, infection, entions included anchoring the excessive tugging on the sfer and deliver of care. The to check the catheter tubing and positioning and to keep the catheter below the level	F3	15			
	R139 's urine possi bladder when the ur bladder and the DO policy for the use of anti-reflux but one w	ASE/PREVENT DECREASE	F 3	18			7. 23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION MAR 1 4 2014	(X3) DATE SURVEY COMPLETED			
		245184	B. WING_	MN Dept of Health	02/07/2014			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION			
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.		F 3-	An assessment for range of materials will be provided for resident I	R135. eceive rvices			
				All residents with a limited rar motion will receive appro treatment and services to incrange of motion and/or to prange of motion. Weekly audits will be conductive.	priate crease revent			
	and development of upper extremity fund on 2/5/2014 at 10:5 fingers were observed resident had no bra 2/7/2014 at 8:45 a.r eating using the left the lap and in a fister interviewed and indictance had no pain. A quarterly Minimum 11/19/2013 was reversely was identified as sewith limited assist of daily living. Functioned for the second residual to the second residu	135 lacked an assessment frange of motion services for ctional limitations. 33 a.m., R135's right hand and ed to be contracted. The ce or splint on the hand. On n., R135 was observed to be hand. The right hand lay in ed position. The resident was icated the right hand did not in Data Set (MDS) dated iewed. R135's cognitive status verely cognitively impaired from staff for most activities tional limitations were for upper or lower rly MDS for 8/21/2013 mpairment as moderate.		monitor compliance. Audit results will be reviewed the QAA process to p	during rovide when uation itoring			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245184	B. WING		02	/07/2014		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 318	limited assist with a functional limitation the upper or lower data set dated 6/17 with moderate cograssist of one staff in functional limita or lower extremities 5/17/13. R135's care plan with 1/29/2013 was refunctioning deficit in and mobility impair addressed a restor but did not address contractures. No physician note is the medical record contracture of the in 12/13/2013, the phocould be heated and On 2/6/2014 at 7:3 prepared R135's won the Rollator wall washing up using lethe right hand. Not do some things but NA-E assisted the inarea. At 8:05 a.m regarding doing rar treatment to the reshe didn't do range shift she would put	age 22 activities of daily living and no as or impairment identified in extremities. Admission MDS 7/2013 identified the resident nitive impairment, extensive for activities of daily living and tion or impairment in the upper s. Also included admission on with completed date of viewed. It identified a physical related to self-care impairment, ment. The interventions at the right hand/finger since admission was evident in that would address the right hand. However, on ysician ordered "mitts" that and used for comfort. 5 a.m., a nurse aide (NA)-E arm water to wash and set it ker seat. The resident was resident with some assist from A-E stated the resident could at depended on the day and resident with the back and perion. NA-E as interviewed and of motion or doing any sident's right hand. She stated of motion but at least once a on the heated glove (light blue was heated up in the	F 318					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245184	B. WING			02	/07/2014
	PROVIDER OR SUPPLIER N LIVINGCENTER - RO	OCHESTER EAST		501	EET ADDRESS, CITY, STATE, ZIP CODE EIGHTH AVENUE SOUTHEAST CHESTER, MN 55904	<u> </u>))
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	On 2/6/2014 at 12:4 not do anything with except wash it real motion or any kind cheated gloves. Social services (SS 2/7/2014 at 9:10 a.r gloves for R135. The applied the heated getaff cannot do that things with heat. She and occupational the should check with the heating gloves on the On 2/7/2014 at 10:4 director (ORD) proving resident was not the control of the	ge 23 Is p.m., NA-F stated she did in the resident 's right hand good. She did not do range of of treatment such as the O-X was interviewed on in. regarding use of the heated he SS-X indicated the family gloves because the facility here. The facility didn 't do he indicated physical therapy herapy seen the resident and hem. The family bought the heir own and brought them in. O a.m. the occupational rehab hided information and stated his seen for a contracture of the hermation did not identify the	F 3	18			
	resident had a contrhand/fingers. On 2/7/2014 at 10:4 of nursing (ADON) with the resident did not hand. The resident discurveyor had not see hand at all. We wern and asked the resident did the third, fourth and straighten out. The hurt. The resident did hand but it was a cloobserved that with the indicated she would which she did. At 10 informed about what						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PRO IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		TE SURVEY	
		245184	B. WING_		0:	2/07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST	STREET ADDRESS, CITY, STATE, ZIP (501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		P CODE	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 318	look at it. All nursing notes from 2/7/2014 were revied documented as far hand/fingers. On 2/director was intervied.	om admission through ewed. Nothing was as contractures of the right 7/2014 at 1:00 p.m., the ORD ewed and stated she verified documentation about the	F 31	8			
	On 2/7/2014 at 2:50 any problems with Frubs hands and the hand but not the rig (RN)-A, thought that but able to use cup required limited ass	p.m., NA-G had not noticed R135. NA-H seen the resident resident could open the left ht hand. Registered nurse t both hands were contracted and walk with walker and istance. RN- A indicated the d been that way since she					
	was interviewed reg hand/finger contract had those for 5 year in the last 3 years. If facility with the right physical therapy (PT help. But as a famil that helped was the the family put the mibecause the facility mitts seemed to help	p.m., R135 's family (F)-A arding the resident's right tures. F-A stated R135 has is or so but had gotten worse R135 was admitted to the hand like that. F-A thought by the only thing they found heating mitts. She indicated tts on when they visit stated they couldn't do it. The bowith the discomfort. Staff ecause they helped the family					
	director (ORD) was i assessment of range	p.m. the occupational rehab nterviewed on the e of motion for residents. g did the range of motion for					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		245184	B. WING	MAR 1 4 2014	02/07/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CADON STATES, ZIP CODE	02/07/2014
GOLDEN	N LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
SS=D	the MDS. According was discharged on therapy services and seeing any issues we (facility staff) would they couldn't do concould do it if they comproached her about they couldn't do concould do it if they comproached her about they couldn't do concould do it if they comproached her about they couldn't do concould do it if they comproached her about the concount of the concount of the concount of the concount of the count of the cou	g to the ORD, the resident 7/1/2013 from Occupation d she didn't ever remember with R135's right hand. They not do the gloves because tinual monitoring but nurses uld monitor it. No one has but evaluating the hand. p.m., MDS nurse (RN)-B was g the assessment data for being no limitations of upper s. RN-B depended on ion and physical therapy right the range of motion for the MDS assessment. Red at residents by passing but did not do a range of ACCIDENT ISION/DEVICES ure that the resident as free of accident hazards ach resident receives and assistance devices to	F 32	Resident R9 is no longer a pathere. He has been discharge home. All residents have potential to be affected. All residents with a falls occurre will receive a thorough investigation and appropriate interventions wite implemented to reduce injury falls. Inservices on falls and intervent was completed with nursing staff February 19 and 20, 2014. DNS and DCE conducted education. Falls are reviewed every day dumorning standup meeting by interdisciplinary team. We audits will be conducted once week x 4 weeks, then once a mex x 3 months and as need thereafter to monitor compliance. Audit results will be reviewed duthe QAA process to province and completion or change with nucleasing and dictate continuation or completion of this monitor process based on compliance. DNS or designee is the responsibility. Corrective Action will be completed.	ed to the ence ation ill be from tions ff on The the tring the ekly e a onth eded ring vide hen tion ring ible
	reduce falls incidents	fective and implemented to for 1 of 1 residents (R9)		by March 19th, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245184	B. WING		***************************************	02/	/07/2014
	PROVIDER OR SUPPLIER	OCHESTER EAST		501	EET ADDRESS, CITY, STATE, ZIP CODE EIGHTH AVENUE SOUTHEAST CHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	reviewed with chror Findings include: Fand the facility did ror determine if curre effective. The Minimum Data dated 12/20/2013 wresident as modera required extensive activities of daily living supervision of one of for personal hygieneresident was frequent to toileting program. An Incident report of was reviewed. It not transfer, had a histon safety. The resident device and was not was a walker.) It was and recommendational arm to remind resummendational arm	set (MDS) on admission was reviewed. It identified the tely cognitively impaired. R9 assist of 2 staff for most and limited assist of one and walking in room. The ently incontinent of urine with and had a history of falls. It had socks on, and had a in use (according to staff, it as reviewed by the facility staff ons were to apply bed/chair ident not to transfer without r incident occurred on p.m. According to the note, ance and slipped and was on ent had a history of falls, ureness, was attempting to books on, and had a device (walker.) The resident in the mid right hip area and bital. R9 remained there until II Recommendations and	F3	23			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING	-		02	/07/2014
	PROVIDER OR SUPPLIER	OCHESTER EAST	•		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 323	The hospital dismis noted: mechanical syncope. The residemental status change courses were ruled encouraged. 1:1 m X-rays were negative done. Physical mediate recommends 24 hospitality. Due to confrequired 1:1 superviconsultations were and cardiology.) R9 's care plan with identified: At risk for 30 days and new en Bed and chair alarma available, contour massistance, footweat environment well lit	sal summary dated 1/17/2014 fall, not secondary to ent developed increased ges. Metabolic and infectious out. Sleep enhancement was onitoring for safety was done. An electrocardiogram was licine was consulted and ur supervision, in skilled fusion and impulsivity R9	F3	323			
	nursing (ADON) sta surveyor that R9 did on after the fall on 1 However, no docum that. When she rev report and investiga not say whether the sounding at the time On 2/7/2014 at 8:20 (DON) indicated who questioned about ho	a.m., the director of nursing en she came; the staff was ow they do incident reports. em out for everything. The					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING		02	2/07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, Z 501 EIGHTH AVENUE SOUTHEA ROCHESTER, MN 55904	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323 F 425 SS=D	On 2/7/2014 at 10:2 interviewed regarding reporting. She state report, checklist, sy (vital signs), and restor future fall. The summaring and then we advised to report. The would review at most about interventions, the resident was postarted a nursing as questions of nursing incident. The incident the ADON and did resounding at the time ADON said it wasn't alarm was sounding was a lack of inform review of the nursing ADON verified the sidetailed and the fall provide all the information and the fall provide all the informati	25 a.m., ADON was ing the system for incident ed the staff fills out incident mptoms, background, VS sponse. For fall: interventions staff is to call the director of could be reported to the state if The next day, clinical manager rning meetings, and discuss The nurse would write what ssibly doing. The facility just ssistant sheet that asked g assistant for their view of the ent reports were reviewed with not address if the alarm was e of the incident or not. The t documented whether the g or not. She verified there nation for the 2nd fall. After g notes of the incident, the second fall notes were not was not documented to mation of the incident. Staff training. MACEUTICAL SVC - EDURES, RPH ovide routine and emergency as to its residents, or obtain	F 32	Residents R8 an discharged from the residents have the affected. All residents will redispensing of medical Education was collicensed nursing stated 19 and February 20 education was conducted and DNS. Random weekly auditive x4 weeks, then once months and as need will be conducted compliance. Audit results will be rethe QAA process redirection or conducted or completion of the process based on cordinate. DNS or designee is the party. Corrective Action will	ceive accurate tions. completed with ff on February D, 2014. The ducted by the ducted by the ducted by the desired to monitor eviewed during to provide hange when the continuation his monitoring mpliance.	3-19-14	
	unlicensed personne law permits, but only supervision of a lice A facility must provide	el to administer drugs if State , under the general		by March 19th, 2014			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	•	245184	B. WING			02	2/07/2014	
	PROVIDER OR SUPPLIER N LIVINGCENTER - RO	OCHESTER EAST		501 EIG	ADDRESS, CITY, STATE, ZIP CODE BHTH AVENUE SOUTHEAST ESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 425	· · · · · · · · · · · · · · · · · ·	_	F 4:	25				
	acquiring, receiving administering of all the needs of each r	drugs and biologicals) to meet						
	a licensed pharmac	nploy or obtain the services of ist who provides consultation provision of pharmacy ty.					0114 6774 786	
	by:	IT is not met as evidenced					25	
	review the facility far were administered v residents (R8 and R	on, interview, and document iled to ensure medications vithout error for 2 of 6 91) whose medication observed during medication						
		was found to have Lidoderm beyond the recommended						
	5% apply to lower ba	s order for Lidoderm patch ack topically every 12 hours mbago. Leave on for up to 12 r period.						
		utlined on the 1/19/14 osteoporotic compression k, dementia.					77 11 	
	on 2/6/14 at 7:14 a.n patch to R8's back.	urse (LPN) - A was observed n. applying the Lidoderm R8 still had a patch on lower LPN-A stated patch had been re and not removed.						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245184	B. WING		02/	07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP CC 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	The nurse practition 2/6/13 at 8:49 a.m. that Lidoderm would someone who had unsure of R8's med patch should have I NP-Z provided a co (Evidence-Based R to Lidoderm. Per N she uses. Micromexcreted through the liver. The Microwas to be "applied"	ner (NP)-Z was interviewed on NP stated she had been told dhave adverse effects to liver problems, but she was ical issues. NP-Z stated the been removed after 12 hours. Py of Micromedix esources) information related P this is the information that edix stated the drug would be ekidney and metabolized by be medix indicated the patch to intact skin and remove the num of 12 hours of application	F 42	25			
	day but had a physical day and the wrong of	luoxetine HCl 20 mg each cian 's order for 30 mg per dose had been given for over ying the order with the					
	dated 1/14/14; reveal 20 milligrams 1.5 ta	f signed physician orders aled orders for fluoxetine HCI blets (30 milligrams) by mouth t date of 12/4/12 and R91 had ession.	·				
	2/6/14, at 8:07 a.m., (LPN-C) administered antidepressant med mouth to R91. Duri	ication, and 20 milligrams by ng interview at that time, nedication label was					
	Document review of	physician orders revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245184	B. WING _		02	/07/2014
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP C 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		. :
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	orders for fluoxetine with start date of 12 Document review of administration records 2/14, revealed fluoxemg) by mouth once 12/4/12. During interview on verified physician of milligrams 1 ½ tables start date was 12/4/without the physician antidepressant. Document review of Medication Review "Medication Review "Medication Administ accuracy. This records and Treatment Administ accuracy. The current MAR newly printed MAR acchanges are reflected. 2. The current MAR newly printed MAR acchanges are reflected. 3. The physician of the medical record of the medical record to determine if there captured on the current and the current of the cur	the facility medication and (MAR) for 12/13, 1/14, and setine HCI (20 mg) 1.5 tab (30 daily with order date of 2/6/14, at 1:54 p.m., LPN-Corders for fluoxetine 20 ets. She verified the order 12, a period of 14 months an ordered 30 milligrams of facility policy Monthly Guideline dated 1/11, read, will be reconciled monthly the factor of the new monthly tration Records and retion Records to ensure and instration will be a three way compares the medical record medication administration Administration Records (MAR) inistration Records (TAR) are and TAR is compared to the fand TAR to determine if all ed on the new MAR/TAR. Set and progress note section dis reviewed for any changes have been any orders not the send and the nurse signs and er sheet to indicate	F 42	5		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			02/07/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, 501 EIGHTH AVENUE S ROCHESTER, MN 55	OUTHEAST	;	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) COMPLETION E DATE	
F 425	Continued From pa	ge 32	F 4	25			
		2/7/14, at 2:13 p.m., interim stated she expected staff to rders and fix any					
·							
						:	
	•						
						1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

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PRINTED: 03/06/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245184 02/05/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or FIRE SAFETY that this Statement of Deficiency was correctly cited, and is also not THE FACILITY'S POC WILL SERVE AS YOUR to be construed as an admission of ALLEGATION OF COMPLIANCE UPON THE fault by the facility, the Executive DEPARTMENT'S ACCEPTANCE. YOUR Director or any employees, agents SIGNATURE AT THE BOTTOM OF THE FIRST or other individuals who draft or may PAGE OF THE CMS-2567 FORM WILL BE be discussed in this Response and USED AS VERIFICATION OF COMPLIANCE. Plan of Correction. In addition, preparation and submission of this UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE Plan of Correction does admission or CONDUCTED TO VALIDATE THAT an constitute agreement of any kind by the facility SUBSTANTIAL COMPLIANCE WITH THE of the truth of any facts alleged or REGULATIONS HAS BEEN ATTAINED IN the correctness of any conclusions ACCORDANCE WITH YOUR VERIFICATION. set forth in the allegations. A Life Safety Code Survey was conducted by the Facility Accordingly, the prepared and submitted this Plan of Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Correction prior to the resolution of Golden Livingcenter - Rochester East was found any appeal which may be filed solely because of the requirements not in substantial compliance with the requirements for participation in under state and federal law that Medicare/Medicaid at 42 CFR, Subpart mandate submission of a Plan of 483.70(a), Life Safety from Fire, and the 2000 Correction within ten (10) days of edition of National Fire Protection Association the survey as a condition to participate in Title 18 and Title 19 (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care programs. This plan of Correction is submitted as the facility's credible PLEASE RETURN THE PLAN OF allegation of compliance. CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** MAR 1 7 2014 (K-TAGS) TO: Health Care Fire Inspections MN DEPT. OF PUBLIC SAFETY State Fire Marshal Division STATE FIRE MARSHAL DIVISION 445 Minnesota St., Suite 145 LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

. . .

7-12-14

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDED/SHAPI JED/JCLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		245184	B. WING		0	2/05/2014	
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, 501 EIGHTH AVENUE SOUTHE ROCHESTER, MN 55904	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
K 000	THE PLAN OF CO	-5145, or .Whitney@state.mn.us RRECTION FOR EACH	K 0	00			
	FOLLOWING INFO 1. A description of v to correct the deficie	what has been, or will be, done				17	
	3. The name and/or responsible for corr						
	3-story building with	enter - Rochester East, is a a full basement. The facility ad was determined to be of action.					
	fire alarm system w detection and space	prinklered. The facility has a ith full corridor smoke es open to the corridor that is natic fire department					
	The facility has a ca census of 105 beds	apacity of 116 beds and had a at the time of the survey.				Ŀ	
K 029 SS=D	NOT MET as evider NFPA 101 LIFE SAF	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD construction (with ¾ hour	K 02	29			

PRINTED: 03/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245184 B. WING 02/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 029 Continued From page 2 K 029 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 K029 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and 1. Open penetrations in the doors. Doors are self-closing and non-rated or storage/repair shop have been field-applied protective plates that do not exceed repaired. Completion date of 3-7-14 48 inches from the bottom of the door are permitted. 19.3.2.1 2. Automatic closure device has been installed on the basementactivity storage room door. Completion date of 3-7-14 This STANDARD is not met as evidenced by: The Maintenance Director will be Based on observation and staff interview, the responsible for correction and facility failed to maintain smoke-resisting monitoring to prevent a partitions and doors in accordance with the reoccurrence of the deficiency. 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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245184 B. WING 02/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) K 029 Continued From page 3 K 029 discovery. K050 K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 3-7-14 SS=D 1. Fire Drills will be conducted at Fire drills are held at unexpected times under sufficient various times and shifts. varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware 2. Maintenance Director has been in that drills are part of established routine. serviced on completing fire drills at Responsibility for planning and conducting drills is sufficient varying times and shifts. assigned only to competent persons who are Completion date of 3-7-14 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded 3. Maintenance Director will be announcement may be used instead of audible responsible for correction and alarms. 19.7.1.2 monitoring to prevent a reoccurrence of the deficiency. 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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SUICOMPLET				
		245184	B. WING		02	/05/2014
	PROVIDER OR SUPPLIER		501	REET ADDRESS, CITY, STATE, ZIP CODE EIGHTH AVENUE SOUTHEAST ICHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 050	Continued From pa	age 4	K 050			
	This deficient practification of the control of the	tice was confirmed by the ce Director (RE) at the time of				
	TEAM COMPOSI Gary Schroeder, Li	TION fe Safety Code Spc.				
3.						
						a #
9						



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 <u>only a suggestion</u> 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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

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 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		02/07/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO)CHESTER FAST	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	this Department's s and the following lic When corrections a date on the bottom marked with "Labor	i, 6 and 7 2014, surveyors of taff visited the above provider censing orders were issued. are completed, please sign and of the first page in the line		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		02/07/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - RO)(:HESTER EAST	TH AVENUE TER, MN 55	SOUTHEAST 904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 000	Continued From pa	ge 1	2 000		
	return the original to Minnesota Departm 18 Wood Lake Driv c/o Gary Nederhoff 507-206-2731 Offic Investigation/s of co H5184077 had bee	e SE, Rochester, MN 55904. , Unit Supervisor		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state safter the statement, "This Rule is as evidence by." Following the sur findings are the Suggested Metho Correction and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." liance is of s the "To order. ings statute not met veyors d of orrection. DING OF TO THIS O DN FOR
2 540	Subpart 1. Assessing conduct a compreh resident's needs, we capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as	D Subp. 1 & 2 Comprehensive ent ment. A nursing home must ensive assessment of each hich describes the resident's in daily life functions and ents in functional capacity. A at conducted according to , section 148.171, subdivision a part of the comprehensive int. The results of the	2 540		
	comprehensive res	ident assessment must be view, and revise the resident's			

Minnesota Department of Health

STATE FORM 6899 0PEL11 If continuation sheet 2 of 29

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER FAST		SOUTHEAST		
0/0.15	CLIMMA DV CTA		TER, MN 559		ON!	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 2	2 540			
	4658.0405. Subp. 2. Information comprehensive resincled at least the A. medically demedical history; B. medical state C. physical and D. sensory and E. nutritional state F. special treat	ion; ential; n potential; itus; v; and				
	by: Based on interview facility failed to accommod pata Set (MDS) as (R135) reviewed with the right hand/finger Findings include: contractures and with However, was observed fingers on the right A quarterly Minimum 11/19/2013 was review was identified as sewith limited assist cof daily living. Funding	R135 was not identified with as not provided services. erved with contracture of 3				

Minnesota Department of Health

STATE FORM 6899 0PEL11 If continuation sheet 3 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		02/	07/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - RO	CHESTER FAST	HTH AVENUE STER, MN 55	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 540	extremities. Quarte identified cognitive limited assist with a functional limitation the upper or lower of dated 6/17/2013 identified cognitive impairment for activities of daily limitation or impairment extremities. Also h 5/17/2013 with diagnostic failure, hypertension pneumonia. On 2/7/2014 at 3:15 coordinator/register interviewed regardifunctional limitation having no limitation extremities). RN-B nursing documentation regards the functional limitation them in the hallway motion evaluation. SUGGESTED MET The MDS (minimumensure the compresident's included significant impairment the MDS coordination and physical therapirandom audit of restructional limitation implemented.	erly MDS for 8/21/2013 impairment as moderate, activities of daily living and notes or impairment identified in extremities. Admission MDS entified R135 with moderate ant, extensive assist of one stary living and no functional ment in the upper or lower ad been admitted on gnoses which included: heart n, dementia, and bacterial				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING.			
		00953	B. WING		02/0	7/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER FAST		SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	TER, MN 559	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive	2 565			
	care of the resident	personnel involved in the				
	by: Based upon observed ocument review, the use of a leg bag act of 1 residents (R1 indwelling catheter. Findings include: Rurine bag higher that the urine to drain be increases the chancinfection. R139 's could be bag below the level provided by staff. On 2/6/14 at 7:45 a head elevated and urinary leg bag on head was higher that	139 was observed to have the an the bladder which allows ack into the bladder which ce of getting a urinary tract care plan for having the urine of the bladder had not been .m. R139 was in bed with his knees bent. R139 had a nis left lower leg and the urine n the bladder at this time.				
	in bed with his cloth elevated with knees observed to be on hand again put the u Licensed practical room to check on ronursing assistant sl the catheter tubing. urine bag to be place	.m. R139 was observed to be nes on and the head of the bed is bent. The leg bag was nis left leg, above the knee rine bag above the bladder. nurse (LPN)-B came into the esident and stated that the nould have put an extender on The extender would allow the ded lower than the bladder and of urine draining back into the				

Minnesota Department of Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	LETED
		00953	B. WING		02/0	7/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER FAST	_	SOUTHEAST		
		ROCHE	STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	bladder. R139 's care plan of there was an alteral related to an indwel 2/1/14 related to inal and out catheterize of urinary tract infection, and would use of indwelling carbeter, avoiding exatheter, avoiding exatheter during transtaff was instructed for proper drainage.	dated 2/1/14 indicated that tion in elimination of bladder lling urinary catheter placed of ability to void and unable to in related to resistance, history ctions, and urinary retention. We R139 free of urinary tracted have no complications from atheter such as pain, infection entions included anchoring the excessive tugging on the laster and deliver of care. The lato check the catheter tubing and positioning and to keep of the catheter below the level	,			
	1/14/14 included the disorder of kidney a On 2/7/14 at 2:10 p LPN-D confirmed the bag that was not ar	n.m., it was observed and nat R139 was wearing a leg nanti-reflux urinary leg bag.				
	concern with R139 directed in the com had been asked to	sing was informed of the not receiving cares as prehensive care plan and also provide a policy for residents ing catheter and care and address provided.				
	Director of Nursing nursing staff follow written. Audits of n be completed on a could be given educ	THOD OF CORRECTION: The or designee could ensure the each resident's care plan as ursing staff giving care could regular basis. Nursing staff cation on the importance of resident care plans as written				

Minnesota Department of Health STATE FORM

OPEL11 If continuation sheet 6 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00953		B. WING		02/0	07/2014
	PROVIDER OR SUPPLIER	OCHESTER EAST	501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From partime PERIOD FOR (21) days.	ge 6 R CORRECTION: Tw	enty One	2 565			
2 570	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requirement by: Based on observation review, the facility foin regards to direct for 1 of 2 residents catheters. Findings include: For catheter but lacked direct staff related to the Urology physician in R133 had a diagnostic interdisciplinary in the catheter but a diagnostic interdisciplinary in the catheter but lacked direct staff related to the catheter but a diagnostic interdisciplinary in the catheter but lacked direct staff related to the catheter but a diagnostic interdisciplinary in the catheter but lacked direct staff related to the catheter but a diagnostic interdisciplinary in the catheter but lacked direct staff related to the catheter but lacked direct staff relate	A comprehensive powed and revised by a methat includes the a red nurse with respond other appropriate simined by the resident practicable, with the resident, the resident representative at least seven days of the resident assessment subpart 3, item B. ent is not met as evicent, interview and docailed to revise the plastaff related to cather (R133) reviewed with the revision of the cather and an indwelling the revision of the cather and the revision of the revision and the revision and the revision of the revision and the revision a	lan of n ttending nsibility taff in t's needs, at evision of t required denced cument an of care ter care of the ter care of the ter to at each onic	2 570			
		d on 2/6/14 at 7:35 a. rsing assistant (NA)-					

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
		00953	B. WING		02/	07/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 E	ET ADDRESS, CITY, S EIGHTH AVENUE HESTER, MN 55	SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 570	replaced the Foley leg bag and then drassisted R133 to we perineal cares which tubing care to preveir irritation from cathed. The care plan printed identified as self-cated toileting assistance infection was identified in the care 2) catheter leg weekly 3) change if provide indwelling of as needed. Secure appropriately. The maintain aseptic tecatheter and did not perineal care. The nursing assistation in a self-cated the facility staff on catheter catheter catheter and care cares, or changing. On 2/6/14 at 2:50 prindicated the facility staff on catheter cathete	catheter bedside bag with a ressed the resident. NA-A ash face, but did not provide his should include catheter ent urinary tract infections a ter. ed 2/7/14 had a problem re impairment that directed. A problem of urinary tract fied. The interventions with toileting or incontinence and bedside bag changed foley catheter every month. Eatheter care every shift and catheter and tubing care plan did not direct statchnique while working with toileter, but did not direct staff to provide a catheter, but did not direct staff the catheter bag. In Director of nursing a did not have a policy to direct catheter bag. In Director of nursing and oviding perineal cares. Also al cares should be provided at cares should be provided and cares should be provided and cares should be provided and cares and tours and care plans when timely manner. Audits couls sure staff were in compliant care staff were in compliant.	de and de			
	TIME PERIOD FOR	R CORRECTION: Twenty C)ne			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00953	B. WING		02/0	7/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH		STATE, ZIP CODE SOUTHEAST 904	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on observatidocumentation, the stage renal disease the health needs of received dialysis services. Findings include: For 1.2 liters (approximate per day) however, to system in place to indictary and nursing keep fluid intake to keeping a record of R116 was maintain day. Physician orders day	ent is not met as evidenced on, interview and facility failed to provide end care and treatments to meet 1 of 1 resident (R116) who evices due to renal failure. R116 was on a fluid restriction imately 5 eight ounce cups he facility did not have a dentify how much fluids would give R116 each day to 1.2 liters nor was anyone the fluid intake to determine if ing no more than 1.2 liters per ated 1/31/14 instructed to a dialysis diet with a 1.2 liter				

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PRINTED: 03/06/2014 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	MHESTER FAST	TH AVENUE TER, MN 559	SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From page 9		2 830			
	fluid restriction was a diagnosis of end and now dialysis de chronic atrial fibrilla R116 admission Mi assessment of nee that R116's brief int (BIMS) was 15 which Also the MDS assesupervision with be and corridor, dress with personal hygie. The nutrition asses that R116 was over activity level and definition and desired the second seco	admitted on 1/16/14 and had stage renal disease (ESRD) ependent, hypertension, tion. nimum Data Set (an ds) dated 1/23/14 indicated erview for mental status ch indicated cognitively intact. ssment showed R116 needed d mobility, walking in rooming, eating and independent				
	included dialysis wi	th 1.2 liter fluid restriction. e to comply with diet				
	his lunch after retur stated that dialysis lunch included carr applesauce and wa also had 3 cups/mu milk, juice and coffe full (which was a to During an interview registered dietician R116 was using he stated that R116 sh those fluids and that meal tray cards ind restriction diet of 1. have 4 ounces of ju lunch which was a	s observed at 2:02 p.m. eating ming from dialysis. R116 run had gone well. R116's ots, meat with gravy, potatoes, ter with his medicine. R116 ags of fluids - consisting of ee, each mug was at least 3/4's tal of 18 ounces of fluids). on 2/7/14 at 3:00 p.m. (RD) stated that the cups ld 8 ounces of fluid. The RD could not have received all at staff needed education. The icated that R116 was on a fluid 2 liters and that R116 was to vice and 4 ounces of water for total of 8 ounces (however, et the amount of fluids at this				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		02/	07/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	meal.) The care plan dated a risk for fluid outpulinstructing staff that liter fluid restriction instructed staff to present to end evidenced by hemoinstructed staff to prestrictions as orderestrictions as orderestrictions. A care R116 had a potential related to: edema, restriction. Intervermaintain fluid restriction. Intervermaintain fluid restrictions and interventions. A care R116 had a potential related to: edema, restriction. Intervermaintain fluid restrictions and interview nurse aide (NA)-C, to R116 following that the nurses known edications. Registered nurse (F2/6/14 at 1:59 p.m., aware that R116 was stated that she did off intake of fluids for During an interview p.m., RD stated that on the resident's coplan. The RD confikeeping track of R1	d 1/27/14 indicated R116 had at exceeding intake and t R116 currently was on a 1.2 daily. One of the interventions rovide R116 to have a 1.2 liter e care plan dated 2/4/12 of alteration in kidney stage renal disease idialysis. Interventions rovide a diet and fluid red by physician. Encourage ritional and hydration program re plan dated 2/4/14 indicated all for alteration in hydration end stage renal disease, fluid intions instructed staff to ction per physician order. per physician orders. on 2/6/14 at 1:55 p.m. with she stated that staff give fluid he tray cards. NA-C indicated we how much to give R116 with as on a fluid restriction. RN-A not have any order to check				

Minnesota Department of Health STATE FORM

E FORM 0PEL11 If continuation sheet 11 of 29

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00953	B. WING	·····	02/0	7/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER FAST	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	times a week. He of medicine before his they don't want him he figures part of hi stated that they (fact away last night. Be strict. R116 stated fluid restriction. The director of nurs on 2/6/14 at 2:48 p. expect the nurses trintake. An undated policy to been provided and monitor a resident's restriction. SUGGESTED MET The Director of Nurthat resident's that	age 11 Indicated he had dialysis three did not recall if he took is dialysis. R116 stated that it to retain fluids so that is why is weight is due to fluids. R116 cility staff), took all his water afore last night they weren't so he understands why he is on a sing (DON) during an interview im. indicated that she would to be monitoring R116's fluid itled Fluid Restriction had no instruction on who would is fluid intake while on a fluid THOD OF CORRECTION: raing or designee could ensure have dialysis needs are sary services. An inservice on	2 830			
	Random audits cou staff were complian	ven to all nursing staff. Ild be completed to ensure the lit. R CORRECTION: Twenty One				
2 895	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	2 895			
	that is directed towa through positioning implemented and m	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00953	B. WING		02/	07/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH	* * * * * * * * * * * * * * * * * * * *	STATE, ZIP CODE SOUTHEAST	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 895	of nursing services development of a nursing services development of a nursing services development of a nursing services appropriate increase range of nursing services appropriate increase in range of mulcorease in range of mulc	must coordinate the ursing care plan which h a limited range of motion e treatment and services to notion and to prevent further of motion. ent is not met as evidenced on, interview and document ailed to assess a resident's need for a restorative services a program for 1 of 1 resident th limited range of motion of 135 lacked an assessment f range of motion services for ctional limitations. 53 a.m., R135's right hand and red to be contracted. The ce or splint on the hand. On m., R135 was observed to be thand. The right hand lay in red position. The resident was icated the right hand did not in Data Set (MDS) dated riewed. R135's cognitive status everely cognitively impaired f one staff for most activities etional limitations were				

Minnesota Department of Health

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	limited assist with a functional limitation the upper or lower of data set dated 6/17 with moderate cograssist of one staff for no functional limitation or lower extremities 5/17/13. R135's care plan with 11/29/2013 was revised functioning deficit reand mobility impairs addressed a restorabut did not address contractures. No physician note sith emedical record contracture of the rith 12/13/2013, the physician could be heated an On 2/6/2014 at 7:35 prepared R135's was on the Rollator walk washing up using lethe right hand. NA-some things but it cassisted the resider At 8:05 a.m. NA-E arange of motion or resident's right hand range of motion or the hestated it was heated On 2/6/2014 at 12:4	activities of daily living and no s or impairment identified in extremities. Admission MDS /2013 identified the resident nitive impairment, extensive or activities of daily living and ion or impairment in the upper s. Also included admission on ith completed date of riewed. It identified a physical elated to self-care impairment, ment. The interventions ative program for ambulation the right hand/finger				

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Minnesota Department of Health STATE FORM

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00953	B. WING		02/	07/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 895	except wash it real motion or any kind heated gloves. Social services (SS 2/7/2014 at 9:10 a.r gloves for R135. The applied the heated staff cannot do that things with heat. She and occupational the should check with the heating gloves on the comparison of the resident was not right hand. The inforces ident had a continuous hand. The resident was not right hand. The resident hand at all. We were and asked the resident surveyor had not see hand at all. We were and asked the resident of the hird, fourth and straighten out. The hurt. The resident of hand but it was a clobserved that with the indicated she would which she did. At 10 informed about what observed and she in look at it.	good. She did not do range of of treatment such as the contract of the heated on m. regarding use of the heated he SS-X indicated the family gloves because the facility here. The facility didn't do be indicated physical therapy berapy seen the resident and hem. The family bought the heir own and brought them in.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	NCHESTER FAST	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 15	2 895			
	hand/fingers. On 2/director was intervies she did not find any right hand/finger co. On 2/7/2014 at 2:50 any problems with I rubs hands and the hand but not the rig (RN)-A, thought the but able to use cup required limited asserted in 5/2013.	as contractures of the right 7/2014 at 1:00 p.m., the ORD ewed and stated she verified of documentation about the intracture. O p.m., NA-G had not noticed R135. NA-H seen the resident resident could open the left the hand. Registered nurse at both hands were contracted and walk with walker and sistance. RN- A indicated the indicated th				
	was interviewed rechand/finger contract had those for 5 years in the last 3 years. facility with the right physical therapy (Phelp. But as a family that helped was the the family put the mbecause the facility mitts seemed to he knew about R135 bwith the mitts. On 2/7/2014 at 3:00 director (ORD) was assessment of rang She indicated nursi the MDS. According was discharged on therapy services are	op.m., R135's family (F)-A garding the resident's right tures. F-A stated R135 has rs or so but had gotten worse R135 was admitted to the thand like that. F-A thought T) worked on that and it didn't ly, the only thing they found the heating mitts. She indicated witts on when they visit stated they couldn't do it. The lp with the discomfort. Staff ecause they helped the family op.m. the occupational rehability interviewed on the ge of motion for residents. In gid the range of motion for g to the ORD, the resident 7/1/2013 from Occupation and she didn't ever remember with R135's right hand. They				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER FAST	TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 16	2 895			
	(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.					
	functional limitation and lower extremition nursing documenta documentation rega functional limitation RN-B stated she lo					
	The Director of Nur resident's with func and assessed on a Resident's identified provided with a pro- further limitation an abilities. The Direct	THOD OF CORRECTION: sing could ensure that tional limitations are identified dmission to the facility. If with functional limitations are gram and treatment to prevent door maintain the resident's ctor of Nursing could give rsing staff regarding treatment nctional limitations.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			
	have a continuous management to recunnecessary use of	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	home must ensure A. a resident w without an indwellin unless the resident' that catheterization B. a resident wh receives appropriat prevent urinary trace		2 910			
	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.					
	Review of the quart dated 1/14/14 indicated included Alzheimer' the brief interview of long and short term	111 did not receive toileting nce with the plan of care. erly Minimum Data Set (MDS) ated R111 had diagnoses that s; was unable to participate in f mental status (BIMS); had memory impairment; was nt of bladder; and did not ting program.				
	lying fully dressed of movement (BM) wa a.m. R111 was rece The room had an o	.m. R111 was noted to be on back in bed. Odor of bowel as noted. On 2/6/14 at 8:30 eiving morning personal cares. dor of urine. Nursing assistant was assisted to the chair				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST GOLDEN LIVINGCENTER - ROCHESTER EAST ROCHESTER, MN 55904 PRIVATE REGULATORY OR LSC IDENTIFYING INFORMATION) 2 910 Continued From page 18 using a standing lift. NA-B stated the resident had been incontinent of urine this sam. NA-B stated filt1 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 shad 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 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 and dated as printed 2/7/14 showed no changes. The nursing assistant worksheet provided 2/7/14 was twing was interviewed on 2/7/14 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		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
SOLDEN LIVINGCENTER - ROCHESTER EAST Sol EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			00953		B. WING		02/	07/2014
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 to lideing 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 2/7/14 at 93.0 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			OCHESTER FAST	501 EIGH	TH AVENUE	SOUTHEAST		
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 toleting 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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
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	using a standing lift had been incontined stated R111 would at to have a bowel mourine. NA-B stated toilet unless the reshad not toileted R11 bed. The care plan dated 2/7/14. The care plurinary tract infection Approaches/interveresident with toiletin Toilet resident upon meals, prior to active two hours during the provided 2/7/14 and showed no changes worksheet provided be toileted every two Licensed practical manager for third we 2/714 at 9:30 a.m. stoileting every 2 hours catheter bags, but cand did not receive contamination. Urology physician in diagnosis of probation normal tone) bladded emptying. During at the provided emptying. During a state of the provided personal tone) bladded emptying. During a state of the provided personal tone) bladded emptying. During a state of the provided personal tone) bladded emptying. During a state of the provided personal tone) bladded emptying. During a state of the provided personal tone) bladded emptying. During a state of the provided personal tone bladded emptying. During a state of the provided personal tone bladded emptying. During a state of the provided personal tone bladded emptying. During a state of the provided personal tone bladded emptying.	NA-B stated the resent of urine this am. Nat times tell staff wherevement, but not if new staff did not put R111 ident asked. NA-B versioner to the staff did not put R111 ident asked. NA-B versioner to the staff did not put R111 ident asked. NA-B versioner to the staff did not put R111 ident asked. NA-B versioner to the staff was to off the staff to the staff was to off the staff to the staff	A-B n needed ed to void on the rified she up from led m of o assist needed. after every re plan /14 ant 1 was to nical wed on er ED TO NS: ging of al care ated a ess than dder at 1:00	2 910			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00953	B. WING		02/0	7/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGH		STATE, ZIP CODE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	an indwelling Foley retention and inabilication are seen as provided to a state of the catheter bag tip and been wiped with an and them. On 2/6/14 at 9:20 a west stated the bag garbage bag and the placed on the insert LPN/CM also stated used to cleanse the On 2/16/14 at 2:50 was interviewed. Shave a policy relate DON also stated the not direct care of the for residents with the stated she would extend to have a policy relate both and them.	rd west unit stated R133 had catheter because of urine ty to void. d on 2/6/14 at 7:35 a.m. during 33's leg catheter bag was re a cap on the insertion port ections. The bladder tubing wrapped in a wash cloth that NA-A to wipe the residents tubing with wash cloth was bed between the residents served to continue dressing ging her soiled gloves and ging her gloves touch the tach the tubing to the leg bag. The personal cares, no perineal to R133. At 7:45 a.m. NA-A bag tip cover was in the athroom. NA-B stated the dicatheter tip should have alcohol pad before attaching the tubing were stored in a feat there was a cap to be attached with the tubing were to be at the dicatheter to protect the tubing. It did not did alcohol wipes were to be a tubing and tips. p.m. the director of nursing the indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing catheter bags. The indicated the facility did not did to changing the indicated the facility did not did to changing the indicated the facility di	2 910			

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		00953	B. WING		02/0	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		501 FIGH		SOUTHEAST		
GOLDEI	N LIVINGCENTER - RO	ROCHES ROCHES	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	Continued From pa	age 20	2 910			
2 910	R139 did not receivurinary tract infectic catheter leg bag. R139's signed phys 1/14/14 indicated thunspecified disorder R139 was admitted R139 was admitted mental status (BIM intact. R139 was intransfers, and amb assist with persona Nurses notes dated complaining of urge attempting to void ramounts. The nurse catheterize residen blockage of some temergency room. home with a diagnorand was started on twice a day for 7 daplaced. On 2/6/14 at 7:45 at head elevated and urinary leg bag on higher than his black. During an interview nurse (LPN)-B on 2 indicated that R139 straight. LPN-B did had an anti-reflux could flow back into was higher than the instructed and remisers.	ve catheter care to prevent on with the use or a urinary sician order sheet dated nat diagnoses included acute, er of kidney and ureter also I on 6/27/13. Minimum Data Set dated R139 had a brief interview for S) of 11 which was cognitively ndependent with bed mobility, ulation. R139 was extensive	2 910			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00953		B. WING		02/	07/2014
	PROVIDER OR SUPPLIER	OCHESTER EAST	501 EIGH		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	to keep the urine bath and his head of be drain properly into ho Dorroll of the levated with kneed	ag lower than the black with LPN-D on 2/6/red that they currently are anti-flow /reflux is e was able to contact will be shipping out a delivered the following in the bag had no events reflux. If 2/5/14 indicates the tibiotic, Cipro, for the ary tract infection. Reflect to keep his legs delevated so the uring leg bag. Im. R139 was observes on and the head es bent. The leg bag is left leg, above the mais leg, above the mais left leg, above the mais leg, ab	14 at y do not n their t a case of ing day. mention at R139 e 139 is straight ne can ved to be of the bed y was e knee. d 2/1/14 velling d to y of urinary The goal fection, use of on, horing the are. The er tubing to keep the level				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00953		B. WING		02/0	07/2014
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST		TH AVENUE TER, MN 559	SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 910	bag that was not an The director of nurs R139's urine poss bladder when the ubladder and the DC policy for the use of anti-reflux but one v SUGGESTED MET The Director of Nur resident toileting ne educating all nursin incontinence and recatheters. Random residents could be or resident's with urina ensure proper services.	nat R139 was wearing anti-reflux urinary less anti-reflux urinary less anti-reflux urinary less anti-reflux urinary less and page anti-reflux urinary less are met as asset as staff on resident's using urinary audits of incontinentary catheters could be ary catheters could be anti-reflux urinary and the staff on the	g bag, med of the han the provide a not TION: uld ensure ssed by with y t vations of e done to	2 910			
21580	Subp. 7. Administ administration of macomplete procedure record, transferring medication from the container, and district resident. This MN Requirements: Based on observations.	5 Subp. 7 Administrative rements cration requirements. Evaluations must include of checking the resident's prescriptive resident's prescriptive resident's prescriptive resident is not met as evicent, interview, and douiled to ensure medical	The de the dent's ne on n to the denced cument	21580			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		00953	B. WING		02/0	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - RO	TOHESTER EAST		SOUTHEAST		
0/0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	TER, MN 559		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21580	Continued From pa	ge 23	21580			
	residents (R8 and F	without error for 2 of 6 R91) whose medication observed during medication				
	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.					
	2/6/13 at 8:49 a.m. that Lidoderm woul someone who had unsure of R8's med	ner (NP)-Z was interviewed on NP stated she had been told d have adverse effects to liver problems, but she was lical issues. NP-Z stated the been removed after 12 hours.				
	to Lidoderm. Per N she uses. Microm excreted through th the liver. The Micro was to be "applied	desources) information related IP this is the information that nedix stated the drug would be ne kidney and metabolized by omedix indicated the patch to intact skin and remove num of 12 hours of application				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00953		B. WING	······	02/	07/2014
	PROVIDER OR SUPPLIER	OCHESTER FAST	01 EIGHT		STATE, ZIP CODE SOUTHEAST 904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21580	R91 had received Fluoxetine HCI 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.		21580				
	Document review of signed physician orders dated 1/14/14; revealed orders for fluoxetine HCI 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 HCI (20 mg) 1.5 tab (30 mg) by mouth once daily with order date of 12/4/12.						
	verified physician o milligrams 1 ½ table start date was 12/4.	2/6/14, at 1:54 p.m., L rders for fluoxetine 20 ets. She verified the or /12, a period of 14 mor in ordered 30 milligram	rder nths				
	Document review of facility policy Monthly Medication Review Guideline dated 1/11, read,						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00953	B. WING		02/0	7/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	ICHESTER FAST	ΓΗ AVENUE ΓER, MN 559	SOUTHEAST 904		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21580	"Medication orders prior to beginning u Medication Administ accuracy. This recipiencheck system that of to current and new records." 1. New Medication and Treatment Administ and Treatment Administ and Treatment Administed. 2. The current MAF newly printed MAR changes are reflect and the current of the medical record to determine if there captured on the current Monitoring for Compates physician ordereconciliation/review. During interview on director of nursing scheck medication of discrepancies. SUGGESTED MET The director of nursing service all employmedication administ proven standards of medications to resident accuracy."	will be reconciled monthly se of the new monthly stration Records and tration Records to ensure onciliation will be a three way compares the medical record medication administration Administration Records (MAR) ministration Records (TAR) are and TAR is compared to the and TAR to determine if all ed on the new MAR/TAR. The reder and progress note section and is reviewed for any changes the have been any orders not trent and/or new MAR/TAR. Pliance-the nurse signs and the sheet to indicate the of medications. 2/7/14, at 2:13 p.m., interimentated she expected staff to	21580			
21670	(21) days. MN Rule 4658.1405 A.B.C.D. Resident Units		21670			

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		00953		B. WING		02/	07/2014
_	PROVIDER OR SUPPLIER	OCHESTER EAST	501 EIGH		STATE, ZIP CODE SOUTHEAST 904	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
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		21670				
	by: Based on observatifailed to provide ad provide morning ca This affects all 17 re	ent is not met as evi on and interview the equate supply of bat res to residents on 3 esidents which include no needed towels for	facility h linens to west. ded				
	R133 was observed 2/6/14 at 7:35 a.m. be washed and drie	d during morning car R133 had been obse d using two wash clo NA)-A stated the third	erved to oths.				

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	PROVIDER OR SUPPLIER	OCHESTER FAST 501 EIGHT		STATE, ZIP CODE SOUTHEAST 904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21670	not have cloth towe cloths in place of the helping NA-A at the hand towel for R133. The linen closet was 3rd floor west at 8:0 towel, no hand towel on 2/6/14 at 8:12 at observed to bring at towel and hand towel and h	Is available so they used wash e towel. NA-B who was time said she could not find a 3. Is checked and observed on 8 a.m. and contained 1 bath els, and 3 wash clothes. Im. social worker (SW)-Z was plastic bag containing 4 bath els to the unit. Im. laundry aid (LA)-A stated or run out of linens sometimes. Im. licensed practical er of third floor west stated she elack of linen this morning for ontinued to say that this has occasions and that a staff we called down to laundry to Im. the laundry director (LD) dhe indicated laundry staff and do the laundry from the tinues to say that the laundry s between 9:00 a.m. and 9:30 the facility had extra linen	21670				
		HOD OF CORRECTION:					

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21670	resident areas had Random audits of e to check on supply schedule could be o residents received of daily cares.	ge 28 enough linens for daily care. each area could be completed of laundry and availability. A developed to ensure all enough laundry to complete as CORRECTION: Twenty One				

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