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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 11K9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245319**

2.STATE VENDOR OR MEDICAID NO.
(L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LA CRESCENT**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **06/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
24-5319
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on June 2, 2014. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been approved.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 6/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245319

June 10, 2014

Ms. Jana Cates, Administrator
Golden Livingcenter - La Crescent
101 South Hill Street
La Crescent, Minnesota 55947

Dear Ms. Cates:

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 May 28, 2014 the above facility is certified for or recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

Your request for waiver of K67 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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,

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2014

Ms. Jana Cates, Administrator
Golden Livingcenter - La Crescent
101 South Hill Street
La Crescent, Minnesota 55947

RE: Project Number S5319023

Dear Ms. Cates:

On May 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 April 18, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 31, 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 April 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 18, 2014, effective May 28, 2014 and therefore remedies outlined in our letter to you dated May 7, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the April 18, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245319	A. Building B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/28/2014**
ID Prefix **F0283** Reg. # **483.20(l)(1)&(2)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/28/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/28/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/28/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/28/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/28/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	06/10/2014	10160	06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/18/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245319	01 - MAIN BUILDING 01	5/31/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0147	05/28/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KFD	Date: 06/10/2014	Signature of Surveyor: 25822	Date: 05/31/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/17/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 11K9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245319**

2.STATE VENDOR OR MEDICAID NO.
(L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LA CRESCENT**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **04/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 04/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
AW K67 Emailed CMS 06/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

24-5319

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction. Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded. Approval of the waiver request will be recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 7, 2014

Ms. Kaitlin Thomas, Administrator
Golden Livingcenter - La Crescent
101 South Hill Street
La Crescent, Minnesota 55947

RE: Project Number S5319023

Dear Ms. Thomas:

On April 18, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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;

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

Remedies - 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;

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

Informal Dispute Resolution - 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, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
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 May 28, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 28, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 July 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 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 an ePoC 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 electronic 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		5/28/14

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

Electronically Signed | 05/16/2014

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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	245319	A. BUILDING _____ B. WING _____	04/18/2014

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to inform the physician of low blood sugar levels timely for 1 of 1 resident (R3) who is diabetic with known history of low blood sugars. Findings include: R3's signed physician's order dated 3/5/14 indicated that the resident was admitted on 3/26/10. According to the physician's progress note dated 3/5/14 resident's diagnoses included: history of hypoglycemia (low blood sugar), Diabetes type 1 (insulin used), end-stage renal disease requiring dialysis, paranoid schizophrenia, seizure disorder, and major depressive disorder. The 30 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 3/28/14 indicated a BIMS (brief interview mental status) score of 15 which indicated that R13's cognition was intact. R3's signed physician orders dated 3/5/14 included: for blood sugars (BS) 60 give GlucoBurst (glucose). Recheck blood sugar in 15-30 minutes. For BS greater (>) 400 give scheduled insulin, if applicable. Recheck BS in	F 157	1. The physician has been notified of low blood sugar levels for R3 in a timely manner as per agreed upon parameters. 2. All diabetic residents have potential to be affected. Blood sugar physician notification parameters have been reviewed for all deabetic residents. Physicians have been notified in a timely manner for low blood sugar levels for all affected residents. 3. Licensed nursing staff have been educated on the physician notification policy and procedures related to diabetic blood sugar management. 4. DNS or designess will complete random audits on diabetic resident charts weekly for four weeks and then monthyly for two months. Results will be communicated to the facility QAPI committee.	

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F 157	Continued From page 2	F 157		

15-30 minutes. Notify MD of BS less than 50 or greater than 500. Another order also stated to give glucose 1 tube gel by mouth for BS 50 and alert medical doctor. May or may not have symptoms of hypoglycemia; Abilify 45 mg daily, Carbamazepine 300 mg twice a day; Lantus (insulin) 15 units subcutaneously (SQ) every day, Novolog (insulin) 8 units SQ at lunch; and Novolog 3 units SQ before meals. Resident also had orders for a sliding scale insulin (based on blood sugar level set amount of insulin is given) to be given before meals and at bedtime.
The electronic vital signs report indicated that on 4/15/14 at 5:30 p.m. R3 had a blood sugar of 37 mg/dl (milligrams per deciliter). The nurse ' s note dated 4/15/14 at 10:32 p.m. indicated that R3 had no insulin this p.m. due to Accucheck low and requiring GlucoBurst for Accucheck of 37 at beginning of shift. There was no documentation that the physician was notified of the low blood sugar. On 4/10/14 at 5:08 R3's blood sugar was 45 and Glucose gel was given by nurse. There was no documentation that the physician was notified of the low blood sugars. On 3/8/14 at 5:15 a.m. R3's blood sugar was 37 mg/dl. According to the communication book used for dialysis there was a documented note on 3/8/14 that R3's blood sugar was 37. Nurse documented that GlucoBurst had been given and that R3 ate a small breakfast and the BS was 186 when rechecked. Lantus insulin had been given. Please make sure she eats. There was no documentation that the physician had been notified.
The Assistant Director of Nursing (ADON)-B in an interview on 4/16/14 at 9:30 a.m. stated that R3 had a low blood sugar yesterday, 4/15/14, and that she had looked for a fax that the physician was notified and could not find one.

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F 157	Continued From page 3 During an interview with physician - D on 4/17/14 at 8:00 a.m. when asked when he would expect to be called for a low blood sugar, he stated typically he would expect to be notified after the treatment for the low blood sugar was done. He stated he didn't know what the current order was and sometimes when they come back from the hospital and the endocrinologist (a physician who specializes in patient/s with diabetes) writes orders and at times it is kind of confusing. Physician-D stated he would expect that if a resident had a low blood sugar that the nurse would treat it and then he would want to be notified even if the blood sugar had gone up above 50. A policy titled Diabetes Management Guideline, revised 2013, indicated that hypoglycemia was defined as blood glucose less than or equal to 70 mg. Whenever a glucose test indicates hypoglycemia (70 or less) treatment should be provided immediately. Residents with a diagnosis of diabetes have an order for blood glucose monitoring. Medical doctor (MD) notification parameters in place, glucose gel are used for hypoglycemic events. An acute management of diabetic resident guideline indicated that the physician would be notified as directed by blood glucose.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		5/28/14

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F 279	Continued From page 4 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop seizure interventions in regards to detecting signs and symptoms of seizures and safety measure to prevent injury and impaired airway on the comprehensive care plan for one of one resident (R3) who was diagnosed as having seizures. Findings include: R3's comprehensive care plan had not addressed the risk factors and interventions for seizure activity related to hypoglycemia. R3's comprehensive care plan dated 4/22/11 was reviewed and did not address signs or symptoms of seizures, possible adverse side effects of the anti-seizure medicine, to alert care givers of the need to immediately report these signs and symptoms to the nurse and how to protect the resident if they have a seizure. R3's signed physician's order dated 3/5/14 indicated that the resident was admitted on	F 279	1. The comprehensive care plan for R3 has been updated to include seizure interventions in regards to detecting signs and symptoms of seizures and safety measures to prevent injury and impaired airway. 2. All comprehensive care plans for residents with diagnosis of seizure have been reviewed and updated as necessary to include seizure interventions in regards to detecting signs and symptoms of seizures and safety measure to prevent injury and impaired airway. 3. Licensed nursing staff have been educated on the update comprehensive care plans and how to develoop comprehensive care plans for residents with diagnosis of seizures. 4. DNS or designeee will complete random audits on charts for residents with diagnosis of seizure for four weeks and then monthly for two months. Results will	

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F 279	Continued From page 5 3/26/10. According to the physician's progress note dated 3/5/14 resident's diagnoses included: history of hypoglycemia (low blood sugar), Diabetes type 1, end-stage renal disease requiring dialysis, paranoid schizophrenia, seizure disorder, and major depressive disorder. R3's signed physician orders dated 3/5/14 indicated that R3 received carbamazepine 300 mg orally twice a day due to having a history of seizures. R3 had been seen in the emergency room due to having seizures a home and R3 was discharged on 2/28/14 and the emergency physician documented the principal diagnosis was seizure due to profound hypoglycemia. The Director of Nursing (DON) on 4/18/14 was unable to provide a specific care plan policy. During a phone call on 4/22/13 the DON stated she did not have a care plan policy.	F 279	be communicated to the facility QAPI committee.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the plan of care for 1 of 1 residents (R3) who had diabetes and had low blood sugars that had not been reported to the doctor according to the plan of care. Findings included:	F 282	1. The facility followed the updated plan of care for R3 who had diabetes and had low blood sugars by notifying the physician of low blood sugars as per the plan of care. 2. All diabetic residents have potential to be affected. Blood sugar physician notification parameters have been	5/28/14

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F 282	Continued From page 6 R3's signed physician's order dated 3/5/14, indicated that the resident was admitted on 3/26/10. According to the physician's progress note dated 3/5/14, R3's diagnoses included: history of hypoglycemia (low blood sugar), Diabetes type 1, end-stage renal disease requiring dialysis, paranoid schizophrenia, seizure disorder, and major depressive disorder. The 30 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 3/28/14, indicated a BIMS (brief interview mental status) score of 15 which indicated that R3's cognition was intact. The MDS indicated that R3 required extensive assist with transfers, dressing and toilet use. R3, interviewed on 4/15/14, at 4:00 p.m., stated she had dialysis on Tuesday, Thursdays and Saturdays. R3 stated that she leaves around 6 a.m., eats breakfast before leaving, and arrives back at the facility for lunch. R3's care plan dated 4/22/11, identifies a problem of alteration in blood glucose due to insulin dependent diabetes mellitus, hyperglycemic (high blood sugar) episodes, and hypoglycemic episodes. The interventions included to observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating, light headedness. Report abnormal results per physician parameters/guideline. The electronic vital signs report indicated that on 4/15/14, at 5:30 p.m. R3 had a blood sugar (BS) of 37 mg/dl (milligrams per deciliter). The nurses note dated 4/15/14, at 10:32 p.m. indicated that R3 had no insulin this p.m. due to Accucheck low and requiring gluco-burst for Accucheck of 37 at beginning of shift. There was no documentation that the physician was notified of the low blood	F 282	reviewed for all diabetic residents. Physicians have been notified in a timely manner for low blood sugar levels for all affected residents. 3. Licensed nursing staff have been educated on the need to follow the plan of care for all diabetic residents. 4. DNS or designee will complete random audits on charts for residents with diagnosis of diabetes for four weeks and then monthly for two months. Results will be communicated to the facility QAPI committee.	

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F 282	Continued From page 7	F 282		

sugar. On 4/10/14 at 5:08 R3's blood sugar was 45. Glucose gel was given by nurse. Again there was no documentation that the physician was notified of the low blood sugar level. On 3/8/14, at 5:15 a.m. R3's blood sugar was 37.0 mg/dl. The dialysis communication book had a note on 3/8/14, that R3's blood sugar was 37. Nurse documented that glucoburst had been given and that R3 ate a small breakfast and the BS was 186 when rechecked. Lantus given. Please make sure she eats. There was no documentation that the physician had been notified.
The assistant director of nursing-B was interviewed on 4/16/14, at 9:30 a.m., and stated that R3 had a low blood sugar yesterday, 4/15/14, and that she had looked for a fax that the physician was notified and could not find one.
R3's physician (P)-D, interviewed on 4/16/14 at 9:30 a.m., stated that if it was that low (in reference to BS of 37) they would not have called him at that time but would have called the on call doctor. On 4/17/14 at 8:00 a.m., P-D stated he would expect to be notified after the treatment for the low blood sugar was done. P-D stated he didn't know what the current order was, sometimes when residents come back from the hospital and the endocrinologist writes orders it is kind of confusing. P-D expected to be notified after licensed staff treated the patient's low blood sugar even if the blood sugar had gone up above 50 after being treated.
A policy titled Diabetes Management Guideline, revised 2013, indicated that hypoglycemia was defined as blood glucose less than or equal to 70 mg. Whenever a glucose test indicates hypoglycemia treatment should be provided immediately. Residents with a diagnosis of diabetes have an order for blood glucose monitoring. MD notification parameters in place,

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F 282	Continued From page 8 glucose gel is used for hypoglycemic events. An acute management of diabetic resident guideline indicated that the physician would be notified as directed by blood glucose.	F 282		
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a discharge summary and recapitulation of stay for 4 of 5 residents (R61, R53, R67, R2) who were discharged from the facility. Findings include: R61 was admitted on 1/1/14, and discharged home on 1/24/14. Nursing documentation indicated the discharge instructions were discussed and medications sent home with the resident. Family was transporting the resident. The care conference note dated 1/16/14, documented a discharge plan for R61. The interdisciplinary discharge summary dated 1/24/14 indicated R61 was discharged to home, but did not include a recapitulation of stay.	F 283	1. R61, R53, R67, and R2 have been discharged from the facility. No poortunity to edit the charts. 2. All residents discharged since the survey have potential to be affected. Discharge summaries and recapitulation of stays have been completed on all dischared residents. 3. Licensed staff have been educated on the policy and procedure to complete discharge summaries and recapitula of stays. 4. DNS or designee will complete random audits on charts for discharged residents for four weeks and then monthly for two months. Results will be communicated to the facility QAPI committee.	5/28/14

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F 283	Continued From page 9 No physician discharge orders, discharge summary or recapitulation of the stay was found in the medical record. R53 was admitted on 11/5/13, and discharged on 11/13/13. Nursing notes on 11/13/13 indicated R53 was discharged home with daughter. R53 had signed a discharge summary, denied pain or discomfort and took along a medication list. The interdisciplinary discharge summary dated 11/13/13 did not indicate where the resident was discharged to and did not include a recapitulation of stay. R67 was admitted to the facility on 2/17/14 and discharged on 3/1/14. On 2/28/14 the physician wrote orders that R67 could be discharged to home on current medications. The nursing documentation on 3/1/14, indicated R67 was discharged to home with the family and that the medication orders were faxed to the pharmacy. Nursing documented the resident denied any questions or concerns regarding discharge order. The interdisciplinary discharge summary dated 3/1/14 indicated R67 was admitted on 2/17/14 but did not indicate where she was discharged to and lacked a recapitulation of stay. R2 was admitted to the facility on 3/5/13 and discharged on 3/17/13. Nursing notes of 3/14/14 stated R2 saw the physician at the clinic and could discharge to home. No written order authorizing discharge was found in the medical record. Nursing notes of 3/17/14 documented discharge instructions were reviewed with R2 and a list of the medications was reviewed. R2	F 283		

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F 283	Continued From page 10 verbalized understanding. A list of follow-up medical appointments was provided to R2. On 3/11/14 at the care conference a documented discharge plan was provided to the resident. The Interdisciplinary Discharge Summary dated 3/17/14 stated R2 was admitted from Winona Health and discharged to home. No recapitulation of stay was documented. The director of nursing (DON) interviewed on 4/17/14, at 10:20 a.m., stated there should be a recapitulation of stay for each resident as well as discharge orders. The DON stated, on 4/17/14 at 11:27 a.m., there was no recapitulation of stay for R61, R53, R67 and R2. The DON also stated there were no written physician discharge orders for R61, R53 and R2.	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to respond appropriately to episodes of low blood sugar for 1 of 1 residents (R3) who was recently hospitalized for a seizure related to low blood sugar. Findings included:	F 309	1. The physician has been notified of low blood sugar levels for R3 in a temely manner as per agreed upon parameters. 2. All diabetic residents have potential to be affected. Bloood sugar physician notification parameters have been	5/28/14

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F 309	Continued From page 11 R3's physician progress note dated 3/5/14, indicated diagnoses that included: history of hypoglycemia (low blood sugar), Diabetes type 1, end-stage renal disease requiring dialysis and seizure disorder. The hospital discharge summary dated 2/28/14, indicated R3 was treated following a seizure due to profound hypoglycemia (low blood sugar) at the facility. The summary indicated that hypoglycemia remained a huge concern and R3's blood glucose should be allowed to run on the higher side. R3's signed physician orders dated 3/5/14 included treatment for hypo/hyperglycemia as follows: For blood sugars (BS) less than 60 give Glycoburst. Recheck blood sugar in 15-30 minutes. For BS greater than 400 give scheduled insulin, if applicable. Recheck BS in 15-30 minutes. Notify MD of BS less than 50 or greater than 500. Another order directed glucose 1 tube gel by mouth for BS 50 and alert MD. May or may not have symptoms of hypoglycemia. The 30 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 3/28/14 indicated a BIMS (brief interview mental status) score of 15 which indicated that R3's cognition was intact. The MDS indicated that R3 required extensive assistance with transfers, dressing and toilet use. R3's care plan dated 4/22/11, included a problem of alteration in blood glucose due to insulin dependent diabetes mellitus, hyperglycemic (high blood sugar) episodes, and hypoglycemic episodes. The interventions included to observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating, light headedness. Report abnormal results per physician parameters/guideline.	F 309	reviewed for all diabetic residents. Physicians have been notified in a timely manner for low blood sugar levels for all affected residents. 3. Licensed nursing staff have been educated on the physician notification policy and procedures related to diabetic blood sugar management. 4. DNS or designee will complete random audits on diabetic resident charts weekly for four weeks and then monthly for two months. Results will be communicated to the facility QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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F 309	Continued From page 12	F 309		

The electronic vital signs report indicated that on 4/15/14 at 5:30 p.m. R3 had a blood sugar of 37 mg/dl (milligrams per deciliter). The nurses note dated 4/15/14 at 10:32 p.m. indicated that R3 had no insulin this p.m. due to Accucheck low and requiring Glycoburst for Accucheck of 37 at beginning of shift. There was no documentation that the physician was notified of the low blood sugar. On 4/10/14 at 5:08 p.m. R3's blood sugar was 45. Glucose gel was administered; however, there was no documentation that the physician was notified. On 3/8/14, at 5:15 a.m. R3's blood sugar was 37.0 mg/dl according to the dialysis communication book. Nurse's documentation indicated Glycoburst had been given and that R3 ate a small breakfast and the BS was 186 when rechecked. There was no documentation that the physician had been notified.

The assistant director of nursing (ADON)-B, interviewed on 4/16/14 at 9:30 a.m. stated that R3 had a low blood sugar yesterday, 4/15/14, but she could not find any evidence the physician was notified.

R3's physician (P)-D, interviewed on 4/16/14 at 9:30 a.m., stated that he or the on-call physician should have been contacted regarding low BS.

R3 was interviewed on 4/15/14 at 4:00 p.m. and stated she received dialysis on Tuesday, Thursdays, and Saturdays. R3 stated that she eats breakfast before leaving around 6:00 a.m. and returns before lunch.

An interview with the dialysis unit nurse, (RN)-G, on 4/16/14 at 1:04 p.m., indicated R3's BS was not checked unless there were symptoms of hypoglycemia. The primary physician would be the one that monitors R3's blood sugars.

During an interview about when to notify the physician of low blood sugars on 4/16/14 at 1:20 p.m., licensed practical nurse (LPN)-B stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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F 309	Continued From page 13 R3's orders had been changed that day. If blood sugar was below 50 they are to give the glycogen and recheck and then call the physician if still below 50 or above 400. LPN-B stated before the change today, she would have called the physician to let him know of the low blood sugar level. On 4/17/14 at 7:00 a.m. the Registered Pharmacist (RP)-C stated that hypoglycemia could be related to R3's other medications, for example the antipsychotic Abilify could cause low blood sugar levels. Physician (P)-D, interviewed on 4/17/14 at 8:00 a.m., stated he would expect that if a resident had a low blood sugar the nurse would treat it and then he would want to be notified even if the blood sugar had gone up above 50. A policy titled Diabetes Management Guideline, revised 2013, indicated that hypoglycemia was defined as blood glucose less than or equal to 70 mg. Whenever a glucose test indicates hypoglycemia treatment should be provided immediately. Residents with a diagnosis of diabetes have an order for blood glucose monitoring. MD notification parameters in place, glucose gel is used for hypoglycemic events.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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F 315	Continued From page 14 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess the risk for urinary tract infections (UTIs) for 4 of 4 residents (R59, R71, R11, R45) identified by the facility as utilizing prophylactic antibiotics to prevent UTIs. Findings include: R59 was observed on 4/14/14 at 9:30 a.m. R59 was alert and oriented, reading the newspaper. During an interview on 4/15/14 at 9:27 a.m., R59 stated she was independent with most of her cares. During an interview on 4/18/14 at 9:45 a.m., nursing assistant (NA)-A stated R59 was independent, but that staff would help with perineal care if R59 requested the help. R59's signed physician orders of 3/14/14 included Keflex (antibiotic) 250 mg by mouth at bedtime for prevention of UTI. The physician documentation of 3/5/14 indicated a problem list of chronic bronchitis, history of depression, anxiety, recurrent urinary tract infections and history of diverticulitis. Physician documentation of 3/6/14 indicated recurrent urinary tract infections. The physician noted R59 did not do well coming off the antibiotic and to continue with current daily antibiotic and monitor for recurring symptoms. Review of the physician documentation of 3/19/14 indicated R59 had a recurrent urinary tract infection, but had no discussion of symptoms of an infection.	F 315	1. The facility assessed the risk for urinary tract infections (UTI's) for residents (R59, R11, R45) identified by the facility as utilizing prophylactic antibiorics to prevent UTI's. R71 has discharged from the facility. 2. All residents who have a history and diagnosis of chronic UTI's have potential to be affected. These residents have been assessed for risk for UTI's. 3. Licensed nursing staff and attending physicians have been educated on the utilization of a UTI risk assessment. 4. DNS or designee will complete random audits on charts for who have a history of chronic UTI's weekly for four weeks and then monthly for two months. Results will be communicated to the facility QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 15	F 315		

The bladder assessment form dated 2/3/14 indicated R59 was continent of bladder. There was no documentation of assessment for any physical abnormalities, recent urinalysis or any post void residuals. The assessment form did not evaluate R59's risk to develop urinary tract infections or that she was on Keflex daily prophylactically. No further urinary/bladder assessment or evaluation was found. The admission Minimum Data Set (MDS) dated 2/5/14 indicated R59 had a BIMS (Brief interview of mental status) score of 14 or cognitively intact, required supervision assistance for toileting and hygiene, was continent of urine, had not had a UTI in the past 30 days. No care area assessment (CAA) was completed.

The care plan printed 3/15/14 indicated R59 required personal hygiene assistance of one and toileting assistance of one as needed. The care plan indicated a problem of at risk for alteration in elimination of bowel and bladder due to history of UTIs with antibiotic or preventions. Interventions directed to monitor and report signs/symptoms of UTI and to provide assistance of one to toilet and to use briefs/pads for incontinence protection.

The director of nursing (DON) was interviewed on 4/18/14 at 9:30 a.m. DON stated R59 had no urinary tract infections (UTIs) since admission. At 9:40 a.m. DON stated she was not able to find a urinary tract infection risk assessment.

R 71 was observed on 4/18/14 at 9:40 a.m. independently utilizing the exercise bike in the therapy room. At 9:44 a.m. on 4/18/14 NA-C stated R71 was mostly independent with perineal cares but required stand by assistance and help

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 16	F 315		

as needed. NA-C stated staff set her up for personal hygiene cares and that R71 would ask for help with transfers.

R71 was admitted on 4/1/14 and had diagnosis listed on the physician notes of 4/2/14 as peripheral neuropathy, diabetes, recurrent constipation, chronic kidney disease and recurrent urinary tract infections.

A urology note dated 2/21/13 stated R71 had a history of recurrent UTI and was on prophylactic antibiotics at bed time. Urology note dated 8/29/13 indicated recurrent UTI and use of prophylactic Trimethoprim (antibiotic) 50 mg at bedtime. Physician orders dated 4/1/14 include Trimethoprim 50 mg by mouth at bedtime for recurrent urinary tract infections.

R71 had a temporary care plan in place that did not address recurrent UTIs or assistance needed for toileting and hygiene. A bladder assessment was not found.

During an interview on 4/18/14 at 9:10 a.m. the director of nursing stated R71 had been treated for a UTI following admission. At 9:40 a.m. DON stated a urinary tract risk assessment had not been completed.
R11 was observed on 4/18/14 at 9:40 a.m. sitting in the lobby reading a newspaper. NA-C was interviewed at 9:44 a.m. on 4/18/14 and stated R11 required total assistance with perineal cares and required extensive assistance with transfers.

R11 was admitted on 12/19/11. Physician notes dated 11/29/12 indicated R11 had a history of chronic urinary tract infections and during a hospitalization had the prophylactic antibiotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 17	F 315		

discontinued. The 11/29/12 documentation indicated that since the discontinuation of the prophylactic antibiotic R11 had experienced three UTIs and the physician felt a prophylactic antibiotic would be warranted. 11/29/12 urology notes indicated recurrent E.Coli UTI.
Physician orders signed 4/16/14 noted Keflex 250 mg by mouth at bed time for urinary tract infection.
A bladder assessment dated 8/23/13 indicated R11 was incontinent of bladder but may have some daily control, received diuretics, was on an antidepressant, and had mild dementia. The assessment identified stress urinary incontinence. The form did not indicate R 11 was assessed for any physical abnormalities, and recent urinalysis, or any post void residuals. The assessment form did not evaluate R11's risk to develop urinary tract infections or that she was on Keflex prophylactically. The care area assessment dated 4/18/14 for urinary incontinence noted incontinent of bladder due to nerve damage during past surgery.
The quarterly MDS dated 2/21/14 indicated R11 had a BIMS score of 15 or cognitively intact, required extensive assistance with toileting and personal hygiene, was always incontinent and had a UTI in the past 30 days.
The care plan printed 3/13/14 identified a problem of physical functioning deficit that directed staff that R11 required assistance of one for personal hygiene and toileting assistance of one to check and change every 2 hours and as needed. The care plan printed 3/13/14 identified a problem of alteration in elimination. Frequent incontinence of bladder with interventions that directed monitor and report signs and symptoms of UTI and provide assistance of one to toilet.
During an interview on 9/24/14 at 9:40 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 18	F 315		

DON stated R11 last had a UTI on June 2013 and that a urinary tract infection risk assessment had not been completed. The DON was unsure if R11 had seen a urologist as recommended by the primary physician but would look. No further information was provided.

R45 was observed on 4/18/14 at 9:35 a.m. sitting napping in her wheelchair. During an interview on 4/18/14 at 9:45 a.m. NA-A stated R45 was continent for the most part and would sneak into the bathroom without assistance. Staff were to wash her perineal area after any incontinent episodes.

R45 was admitted on 11/17/12. A physician visit note of 3/5/14 listed diagnoses of chronic kidney disease and incontinence. A physician visit note of 5/2/13 noted R45 was on Ditropan XL (treat overactive bladder) and also taking Trimethoprim for UTI prophylaxis. Physician orders signed 3/5/14 included Trimethoprim 100 mg for UTI at bedtime

The bladder assessment dated 11/14/13 noted incontinence with leakage on way to bathroom frequently. The assessment did not address possible physical abnormalities, recent urinalysis or post void residuals. The assessment did not evaluate R45's risk to develop urinary tract infections or that she was on Trimethoprim daily prophylactically. The care area assessment dated 1/27/13 identified R45's incontinence, but did not evaluate the chronic urinary tract infection risk.
The quarterly MDS dated 2/14/14 indicated a BIMS score of 6 or severe cognitive impairment, frequent incontinence, assist of one with toilet use and personal hygiene, and no UTIs in the past 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 19 days. The care plan for physical functioning deficit printed 3/15/14 directed personal hygiene assistance of one and assistance with perineal care at least once each shift. The care plan printed 3/15/14 identified alteration in elimination of bowel and bladder, frequent functional incontinence and directed monitor and report signs and symptoms of UTI. During an interview on 4/18/14 at 9:30 a.m. the DON stated R45's last UTI was in May 2013 and that she was not able to find a UTI risk assessment.	F 315		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify, assess and monitor clinical indications for use of psychoactive medications for 3 of 5 residents (R56, R19, R8) reviewed for unnecessary medications. Findings include: R56 was admitted on 11/18/13. Physician orders dated 3/28/14, identified diagnoses that included closed fracture part neck femur, malignant neoplasm of breast, anxiety state and depressive disorder. The quarterly Minimum Data Set (MDS) dated 2/17/14, identified brief interview of mental status (BIMS) had been 12 out of 15 and indicated moderate cognitive impairment. R56 had near constant pain rated eight on the scale of one to ten and no behaviors. R56 received scheduled pain medication, PRN (as needed) medication and non-medication interventions for pain. R56's current physician orders dated 3/38/14, revealed an order for lorazepam (Ativan) (an anti-anxiety medication) 0.5 mg (milligrams) every eight hours as needed (PRN) for anxiety, oxycodone-acetaminophen (a pain medication) 5-325 mg one to two tabs every four hours PRN for pain, do not exceed 12 tablets per day (no indication on physician orders identified when to give one tablet or two tablets) and Tylenol (a pain medication) 650 mg once a day at HS (bedtime) PRN for pain.	F 329	1. The facility identified, assessed and monitored the clinical indications for use of psychoactive and PRN pain medications for residents (R56, R19, R8). 2. All residents who have prescribed psychoactive and/or PRN pain medications have potential to be affected. The facility identified, assessed and monitored the clinical indications for use of psychoactive and PRN pain medications for all residents perscribed psychoactive and/or pain medications. 3. Licensed nursing staff have been educated on the need to identify, assess and monitor the clinical indications for use of psychoactive and PRN pain medications. 4. DNS or designee will complete random audits on charts who have been prescribed psychactive or PRn pain medications weekly for four weeks and then monthly for two months. Results will be communicated to the facility QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 During review of R56's medication administration records the following had been noted: from the dates of 3/17/14 through 3/31/14 R56 had had received a total of 18 doses of PRN lorazepam, 35 doses of PRN oxycodone-acetaminophen, 3 doses of PRN Tylenol and from the dates of 4/1/14 through 4/16/14 R56 had received 14 doses of PRN lorazepam, 24 doses of PRN oxycodone-acetaminophen, one dose of PRN Tylenol. R56's progress notes dated 3/17/14 through 4/16/14 identified the use of the Ativan was not clearly identified as to parameters to why it was given. During interview on 4/17/14, at 2:25 p.m., Assistant director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. During interview on 4/17/14, at 2:59 p.m., Director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. On 4/17/14, at 3:52 p.m., director of nursing state she would expect consultant pharmacist to have identified parameters and non-pharmacological measure concerns. Document review of the facility policy controlled substance prescriptions dated revised 11/11, read " Procedures A. Elements of controlled substance prescription: 13) PRN (as needed) orders clearly delineate the condition for which they are being administered, for example, " as needed for severe pain (pain scale 7-10), " or " as needed for sleep. " Facility director of nursing provided only page one of four of policy.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22	F 329		

R19's received Celexa an antidepressant without identified mood symptoms to monitor if it was effective or not.
R19's physician orders dated 4/16/14 indicated that R19 was admitted on 7/11/13 with diagnoses including, but not limited to: delusional disorder, dementia with behavioral disturbance, anxiety state, generalized pain and chronic kidney disease state III (moderate).
The quarterly Minimal Data Set (MDS) dated 3/12/14 indicated that R19's BIMS (brief interview mental status) was 9 out of 15 indicating cognitively moderately impaired.
During the review of R19's physician orders dated 4/16/14 it was indicated that R19 received Celexa 10 mg one time a day for anxiety state.
R19's comprehensive care plan dated 7/24/13 indicated a problem that R19 was receiving an antidepressant medication and that R19 had the potential to show signs and symptoms of mood concerns. The goal indicated that R19 would talk about positive topics and happy memories during conversations. Interventions included: encourage to get involved in activities related to interests, help keep in contact with family and friends, to give medications that help with depression and manage any side effects, and to take the time to discuss feelings when feeling sad. A second problem dated 8/2/13 indicated that there was a potential for drug related complications associated with the use of psychotropic medications related to antidepressant medication. Interventions included to assess for pain, monitor for side effects and report to physician, monitor for signs/symptoms of depression including isolating self to room, making negative statements and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23	F 329		

document. Report changes to physician.
Monthly pharmacy review of medication regimen.
Provide non-pharmaceutical interventions of visits with family and friends, attending activities like bingo and music programs, resting in recliner with feet up. To decrease target behaviors, anxiety or depression.
During observation and interview with R19 on 4/16/14 at 7:29 a.m. resident was observed walking out of the bathroom with a nursing assistant. R19 stated it's better once she gets up and moving around. During observation on 4/16/14 at 8:13 a.m. R19 was out in the dining room and was observed laughing and conversing with her tablemates and the administrator.
An interview with nursing assistant (NA)-D on 4/17/14 at 1:08 p.m., when asked how R19 displayed her anxiousness or mood, NA-D stated that she would get very upset about her whirlpool and not wanting to get her hair ruined. There were no comments about mood or symptoms associated with it.
During an interview with LPN-A on 4/17/14 at 2:15 p.m. when asked about R19's behaviors or moods, LPN-A stated that she didn't know what the hallucinations were, and LPN-A stated that she was unclear what R19's symptoms were for the use of the antidepressant.
During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that R19 was recently hospitalized for a delusional disorder. For R19's depression, the DON stated that R19 would not come out of her room.
A review of the behavior monthly flow sheet for February, April and March of 2014, indicated that depressed withdrawn and hallucinations/paranoia/delusion was the behavior code. Mood changes were not being monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

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F 329	Continued From page 24	F 329		

Documentation indicated no behaviors observed except one time in February 2014 for depressed/withdrawn with no individualized mood indicator.
The quarterly interdisciplinary resident review dated 3/12/14 under behavioral symptoms indicated none, with the use of an antidepressant. Marked anxious at times, with no individual or quantitative behavior documented.
No policy on targeted behaviors were provided after being requested on 4/18/14.

R8 received an antidepressant medication yet there were no clear mood symptoms/signs specific to this resident identified to determine if the antidepressant was affective or not.
R8's physician orders dated 4/1/14 indicated that R8 was admitted on 11/26/05 with diagnoses including: senile dementia, hemiplegia, depressive disorder, and generalized anxiety disorder.
The quarter MDS dated 3/20/14 indicated R8's BIMS score was 9 out of 15 which indicated cognition was moderately impaired.
The physician's order dated 4/1/14 indicated that R8 was receiving Zoloft 50 mg every day for depressive disorder.
The comprehensive care plan dated 5/21/11 had a problem of R8 feeling sad and restless, irritable, lonely, angry. No mood behaviors were identified.
During an interview with R8 on 4/16/14 at 7:05 a.m., resident was waiting for breakfast in room while watching TV R8 stated her appetite was pretty good and she didn't really like watching TV
During observation on 4/16/14 at 8:09 a.m. while R8 was in the dining room at a table by self, no behaviors of yelling out were observed.
A review of the behavior monthly flow sheet for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

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F 329	Continued From page 25 February, March, and April of 2014 indicated that R8's behavior code was angry and continuous screaming/yelling. No individualized mood changes were identified. During an interview with nursing assistant (NA)-D when asked how R8 displays mood changes, NA-D stated that R8 is attention-seeking, yells out, and is irritable but had no comments about symptoms associated with depression. During an interview with (LPN)-A, when asked about how R8 displays mood behaviors LPN-A stated that she had never seen R8 scream or yell out and did not know any identified mood behaviors. During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that a long time ago R8 had sexually inappropriate behaviors and has some issues with yelling out. There was no monitoring of mood.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 428	1. The facility pharmacy consultant	5/28/14

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F 428	Continued From page 26 facility failed to ensure the pharmacy consultant identified lack of parameters for as needed pain medications for 1 of 5 residents (R56) and failed to identify lack of monitoring 2 of 5 residents (R19, R8) for psychotropic medications reviewed for unnecessary medicatioins. Findings include: R56 was admitted on 11/18/13. Physician orders dated 3/28/14, identified diagnoses that included closed fracture part neck femur, malignant neoplasm of breast, anxiety state and depressive disorder. The quarterly Minimum Data Set (MDS) dated 2/17/14, identified brief interview of mental status (BIMS) had been 12 out of 15 and indicated moderate cognitive impairment. R56 had near constant pain rated eight on the scale of one to ten and no behaviors. R56 received scheduled pain medication, PRN (as needed) medication and non-medication interventions for pain. R56's current physician orders dated 3/38/14, revealed an order for lorazepam (Ativan) (an anti-anxiety medication) 0.5 mg (milligrams) every eight hours as needed (PRN) for anxiety, oxycodone-acetaminophen (a pain medication) 5-325 mg one to two tabs every four hours PRN for pain, do not exceed 12 tablets per day (no indication on physician orders identified when to give one tablet or two tablets) and Tylenol (a pain medication) 650 mg once a day at HS (bedtime) PRN for pain. During review of R56's medication administration records the following had been noted: from the dates of 3/17/14 through 3/31/14 R56 had had received a total of 18 doses of PRN lorazepam,	F 428	identified lack of parameters for as needed pain medications for resident (R56) and identified lack of monitoring for residents (R19, R8) for psychotropic medications. The consultant communicated findings and recommendations to the facility DNS. 2. All residents have ptential to be affected. The facility has ensured that the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist. The pharmacist reported any irregularities to the attending physician, and the director of nursing, and these reports were acted upon. 3. The facility pharmacy consultant and DNs were educated on the expectation that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 4. DNS or designee will complete random audits on charts monthly for three months to confirm all residents have been reviewed by the pharmacy consultant at least once a month and that irregularities were communicated appropriately to the DNS and attending physicians. Results will be communicated to the facility QAPI committee.	

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	245319	A. BUILDING _____ B. WING _____	04/18/2014

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F 428	Continued From page 27 35 doses of PRN oxycodone-acetaminophen, 3 doses of PRN Tylenol and from the dates of 4/1/14 through 4/16/14 R56 had received 14 doses of PRN lorazepam, 24 doses of PRN oxycodone-acetaminophen, one dose of PRN Tylenol. R56's progress notes dated 3/17/14 through 4/16/14 identified the use of the Ativan was not clearly identified as to parameters to why it was given. During interview on 4/17/14, at 2:25 p.m., Assistant director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. During interview on 4/17/14, at 2:59 p.m., Director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. On 4/17/14, at 3:52 p.m., director of nursing state she would expect consultant pharmacist to have identified parameters and non-pharmacological measure concerns. Document review of the facility policy controlled substance prescriptions dated revised 11/11, read " Procedures A. Elements of controlled substance prescription: 13) PRN (as needed) orders clearly delineate the condition for which they are being administered, for example, " as needed for severe pain (pain scale 7-10), " or " as needed for sleep. " Facility director of nursing provided only page one of four of policy. R19's received Celexa an antidepressant without identified mood symptoms to monitor if it was	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

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F 428	Continued From page 28	F 428		

effective or not.
R19's physician orders dated 4/16/14 indicated that R19 was admitted on 7/11/13 with diagnoses including, but not limited to: delusional disorder, dementia with behavioral disturbance, anxiety state, generalized pain and chronic kidney disease state III (moderate).
The quarterly Minimal Data Set (MDS) dated 3/12/14 indicated that R19's BIMS (brief interview mental status) was 9 out of 15 indicating cognitively moderately impaired.
During the review of R19's physician orders dated 4/16/14 it was indicated that R19 received Celexa 10 mg one time a day for anxiety state.
R19's comprehensive care plan dated 7/24/13 indicated a problem that R19 was receiving an antidepressant medication and that R19 had the potential to show signs and symptoms of mood concerns. The goal indicated that R19 would talk about positive topics and happy memories during conversations. Interventions included: encourage to get involved in activities related to interests, help keep in contact with family and friends, to give medications that help with depression and manage any side effects, and to take the time to discuss feelings when feeling sad. A second problem dated 8/2/13 indicated that there was a potential for drug related complications associated with the use of psychotropic medications related to antidepressant medication. Interventions included to assess for pain, monitor for side effects and report to physician, monitor for signs/symptoms of depression including isolating self to room, making negative statements and document. Report changes to physician. Monthly pharmacy review of medication regimen. Provide non-pharmaceutical interventions of visits with family and friends, attending activities like

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F 428	Continued From page 29 bingo and music programs, resting in recliner with feet up. To decrease target behaviors, anxiety or depression. During observation and interview with R19 on 4/16/14 at 7:29 a.m. resident was observed walking out of the bathroom with a nursing assistant. R19 stated it's better once she gets up and moving around. During observation on 4/16/14 at 8:13 a.m. R19 was out in the dining room and was observed laughing and conversing with her tablemates and the administrator. An interview with nursing assistant (NA)-D on 4/17/14 at 1:08 p.m., when asked how R19 displayed her anxiousness or mood, NA-D stated that she would get very upset about her whirlpool and not wanting to get her hair ruined. There were no comments about mood or symptoms associated with it. During an interview with LPN-A on 4/17/14 at 2:15 p.m. when asked about R19's behaviors or moods, LPN-A stated that she didn't know what the hallucinations were, and LPN-A stated that she was unclear what R19's symptoms were for the use of the antidepressant. During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that R19 was recently hospitalized for a delusional disorder. For R19's depression, the DON stated that R19 would not come out of her room. A review of the behavior monthly flow sheet for February, April and March of 2014, indicated that depressed withdrawn and hallucinations/paranoia/delusion was the behavior code. Mood changes were not being monitored. Documentation indicated no behaviors observed except one time in February 2014 for depressed/withdrawn with no individualized mood indicator.	F 428		

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F 428	Continued From page 30 The quarterly interdisciplinary resident review dated 3/12/14 under behavioral symptoms indicated none, with the use of an antidepressant. Marked anxious at times, with no individual or quantitative behavior documented. No policy on targeted behaviors were provided after being requested on 4/18/14. R8 received an antidepressant medication yet there were no clear mood symptoms/signs specific to this resident identified to determine if the antidepressant was affective or not. R8's physician orders dated 4/1/14 indicated that R8 was admitted on 11/26/05 with diagnoses including: senile dementia, hemiplegia, depressive disorder, and generalized anxiety disorder. The quarter MDS dated 3/20/14 indicated R8's BIMS score was 9 out of 15 which indicated cognition was moderately impaired. The physician's order dated 4/1/14 indicated that R8 was receiving Zoloft 50 mg every day for depressive disorder. The comprehensive care plan dated 5/21/11 had a problem of R8 feeling sad and restless, irritable, lonely, angry. No mood behaviors were identified. During an interview with R8 on 4/16/14 at 7:05 a.m., resident was waiting for breakfast in room while watching TV R8 stated her appetite was pretty good and she didn't really like watching TV During observation on 4/16/14 at 8:09 a.m. while R8 was in the dining room at a table by self, no behaviors of yelling out were observed. A review of the behavior monthly flow sheet for February, March, and April of 2014 indicated that R8's behavior code was angry and continuous screaming/yelling. No individualized mood changes were identified.	F 428		

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F 428	Continued From page 31 During an interview with nursing assistant (NA)-D when asked how R8 displays mood changes, NA-D stated that R8 is attention-seeking, yells out, and is irritable but had no comments about symptoms associated with depression. During an interview with (LPN)-A, when asked about how R8 displays mood behaviors LPN-A stated that she had never seen R8 scream or yell out and did not know any identified mood behaviors. During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that a long time ago R8 had sexually inappropriate behaviors and has some issues with yelling out. There was no monitoring of mood.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		5/28/14

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F 431	Continued From page 32 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that narcotics in the emergency kit were stored properly in 1 of 1 medication rooms and failed to ensure expired medication was not available for use for 1 of 1 residents (R12). During the tour of the medication storage room it was observed that the emergency kit which contained narcotics were stored under a single secure lock only and are to be stored in separately locked, permanently affixed compartments, except when the facility uses single unit medication distribution systems in which the quantity stored is minimal and a missing dose can be readily detected; and controlled medications are reconciled accurately. On 4/17/14 at 3:12 p.m. during the medication room storage tour it was noted that the emergency kit had a tag on it but was not locked secured except by the lock on the door to the	F 431	1. The facility ensured that narcotics in the emergency kit were stored properly in the medication room and ensured expired medication was not available for use for resident (R12). 2. All residents have potential to be affected by these practices. The narcotics in the emergency kit have been properly stored. Expired medication for all residents have been removed. 3. Licensed nursing have been educated on the need to properly store the narcotics in teh emergency kit and the need to remove all expired and unlabeled medications. 4. DNS or designee will complete random audits on the medication room monthly for three months to confirm all narcotics are sotred properly. DNS or designess will complete random audits on medication carts weekly for four weeks and then monthly for two months to confirm expired	

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F 431	Continued From page 33 storage room. This was confirmed by registered nurse (RN)-B. The Director of Nursing (DON) on 4/17/14 at 3:33 p.m. confirmed this and also confirmed that the following was in the emergency kit: Diazepam Injection 5 mg/ml (Valium) 1- 10 ml vial. Hydrocodone/Apap 5/325 mg (Lortab)12 tablets. Lorazepam 0.5 mg (Ativan), Morphine Sulfate 20 mg/ml 1 30 ml vial, and oxycodone 5 mg, 12 tablets. A policy titled Controlled Substance Storage dated 05/12 indicated that schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications or per state regulation. On 4/17/14 at 3:12 p.m. during the review of the 100 Wing cart with RN)B it was noted that a bottle of nitroglycerin tablets had the seal broken and ready for use for R12. This was undated as to when it was opened and it had been filled on 12/31/12 through Health Direct Pharmacy. The expiration date was 4/2013. RN-B stated that she thought that R12 had brought them in upon admission. RN-B confirmed that these were expired and did not have the date on it when it had been opened. The physician order's dated 3/19/14 indicated that R12 was admitted on 11/11/13 with diagnoses including senile dementia, chronic ischemic heart disease, anxiety state, depressive disorder, esophageal reflux, and paralysis agitans. The quarterly Minimum Data Set (MDS) dated 2/18/14 indicated her BIMS (Brief Interview for Mental Status) was a score of 9 out of 15 indicating	F 431	and/or unlabeled medications have been removed. Results will be communicated to the facility QAPI committee.	

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F 431	Continued From page 34 moderately impaired cognition. A signed standing orders dated 11/12/13 indicated that R12 could receive nitroglycerin 1/150 (0.4 mg) sublingual (SL) as necessary for chest pain. May repeat x 2 at 5-minute intervals. When discussed with the DON on 4/17/14 at 3:33 p.m. after the tour of the medication room and a policy requested, the DON provided the CQI Process Example: Medication Storage dated 05/12. This process had a check off list that included that expired, deteriorated or contaminated medications are properly identified, removed from the medication cart, stored and disposed of properly. It also indicated that schedule II medications are maintained in double-locked storage with restricted access.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 35 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain sanitary procedures during wound dressing change for 1 of 2 residents (R43) reviewed for wound care; failed to implement procedures to prevent the possible spread of infection during blood glucose monitoring observations for 1 of 2 resident (R18) who had blood sugars taken. Findings Include: R43 was observed during a wound dressing change to the foot on 4/16/14 at 10:12 a.m. with licensed practical nurse (LPN)-A. LPN-A used exam gloves to remove the dressing and clean the area with wound cleanser. LPN removed her gloves and went to the supply cupboard to obtain an opened box of tubular gauze which she sat on	F 441	1. The facility maintained sanitary procedures during wound dressing change for resident (R43). Resident (R43) has been discharges. The facility implemented procedures to prevent the possible spread of infection during blood glucometer cleaning process for resident (R18) after blood surgars taken. 2. All residents who have orders for dressing changes and blood sugar monitoring have potential to be affected. The facility maintained sanitary procedures during would dressing changes for residents who have orders for dressing changes. The facility implemented procedures to prevent the possible spread of infection during blood glucometer cleaning process for residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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F 441	Continued From page 36 R43's over the bed table. LPN-A put on clean gloves and applied a new dressing. LPN-A applied a sterile telpha pad to the area with her right hand. She then took tube gauze that was sitting on the over bed table out of the box with her right hand, cut the gauze with a scissors from her pocket using her left hand and returned the roll of tube gauze to the table. She applied the tube gauze to R43's foot. After removing her gloves, LPN-A placed the roll of tube gauze into the box and stated she was going to take it back to the storage closet. The director of nursing (DON) was interviewed on 4/16/14 at 10:30 a.m. DON stated the tubular gauze should not have been opened and in the storage closet. DON stated only sealed dressing were to be kept in the storage closet. If a dressing was to used for the resident, that dressing should be kept with the other treatments in the cart. The DON stated the dressings were now contaminated. R18 had blood drawn on 4/16/14, at 7:25 a.m., for a blood glucose level. Registered nurse (RN)-A was observed to check R18's blood sugar during which RN-A had gloves on and had removed and discarded the used blood glucose strip sticking out of the glucometer (which had visible blood on end of strip sticking out of the glucometer) into a sharps container hanging on R18' s room door. RN-A had then carried the glucometer out into the hallway to the medication cart, laid the glucometer on the medication cart (glucometer had not been cleaned), removed gloves, washed hands and proceeded to start setting up to pass medications. Surveyor intervened and verified at the time with RN-A the glucometer had not been	F 441	who have orders for blood sugar monitoring. 3. Licensed nursing staff have been educated on the proper sanitary procedures for wound dressing changes and blood glucometer cleaning. 4. DNS or designee will complete random observations on nurses completing wound dressing changes weekly for four weeks and then monthyly for two months. DNS or desingee will complete random observations of nurses completing blood glucometer cleaning weekly for four weeks and then monthly for two months. Results will be communicated to the facility QAPI committee.	

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F 441	Continued From page 37	F 441		

cleaned. RN-A had stated, I won't clean it until I put it away." RN-A stated only one glucometer for each medication cart, the glucometer is shared between residents and had stated uses an alcohol pad to clean the glucometer. RN-A had proceeded to pick up the glucometer without gloves on and clean the glucometer with an alcohol pad. RN-A verified at the time had no gloves on when cleaning the glucometer and had used an alcohol pad to clean the glucometer. However, the glucometer had not been sanatized with a product recommended to kill blood bourne diseases.

During interview on 4/16/14, at 1:00 p.m., director of nursing had stated she would expect policy to be followed and use wipe for cleansing for one full minute as policy states for cleaning the glucometer and gloves are to be worn when cleaning the glucometer.

Document review of facility policy GLUCOMETER DECONTAMINATION dated 12/2/13, read "PURPOSE: To implement a safe and effective process for decontaminating glucometers. Dispatch wipes will be used as a Glucometer disinfectant. This is EPA registered as tuberculocidal; effective against HIV, HBV, and a broad spectrum of bacteria. It is hypochlorite based and meets recommendations for use on equipment for Clostridium difficile rooms. If Dispatch is not available, a 1:10 bleach solution may be substituted. POLICY: The glucometer will be decontaminated with a Dispatch wipe following use on each resident. Gloves will be worn and the manufacturer's recommendations will be followed. Procedure: I. The nurse will obtain the glucometer along with the dispatch wipes and place the glucometer on the overbed table on a

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	245319	A. BUILDING _____ B. WING _____	04/18/2014

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F 441	Continued From page 38 clean surface. II. After performing the glucometer testing, the nurse, wearing gloves, will use a dispatch wipe to wipe all external parts of the glucometer. III. The clean glucometer will be placed on another paper towel. IV. Gloves will be removed and hand hygiene performed. V. The glucometer will be placed in the medication cart or other clean storage area until needed."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure faucets were clear of calcification build up on bathroom faucets to promote a sanitized able surface for 3 of 5 bathrooms whose faucets were coated with calcification build-up. Findings include: An observation on 4/14/14 at 6:10 p.m. indicated that bathroom faucets in rooms 104, 205, and 209, had calcification of lime built up around spigot and knobs. An interview on 4/14/14 at 6:10 p.m. with Maintenance-A verified the faucets were lime covered and felt that they would need to be replaced. Maintenance-A stated they have hard water and only the warm water is softened. During an environmental tour with (maintenance) - D, on 4/17/14 at 9:15 a.m. maintenance-D indicated that the spigot and knobs on the sink in	F 465	1. The three faucets in three identified bathrooms have been cleaned or replaced as necessary. 2. All residents have potential to be affected by this practice. All faucets were either cleaned or replaced as necessary due to calcification. 3. The Maintenance Director has been educated on the need to monitor and address the calcification of resident rooms faucets. 4. The ED or designee will complete random audits of resident rooms faucets monthly for three months. Results will be communicated to the QAPI committee.	5/28/14

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	245319	A. BUILDING _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 39 room 209 had been replaced. Maintenance-D confirmed that room 104 in the bathroom had the faucet with lime covered and the screws holding the sink onto the walls were uncovered. And that in room 205 the bathroom sink faucet at the end of the spigot had thick lime built up and that the turn knobs were pitted.	F 465		

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	245319	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - La Crescent was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2014

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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	245319	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2014**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - La Crescent, is a 1-story building with no basement. The facility was constructed in 1968 and was determined to be of Type II(000) construction. The facility is fully sprinklered and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 40 beds at the time of the survey.	K 000		
K 067 SS=F	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		~~5/28/14~~

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K 067	Continued From page 2 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 40 residents. Findings include: On facility tour between 9:00 AM and 11:30 AM on 04/17/2014, observation and interview with the facility Maintenance Director (MO), revealed that the ventilation system in the 100 and 200 wings, utilizes the egress corridor as the supply air for the resident rooms. This deficient practice was confirmed by the facility Maintenance Director (MO) at the time of discovery.	K 067	1. Waiver request for this deficiency has been submitted.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA	K 147	1. The facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA101-19.5.5,	5/28/14

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K 147	Continued From page 3 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 10 out of 40 residents. Findings include: On facility tour between 9:00 AM and 11:30 AM on 04/17/2014, Observation revealed, that the circuit breaker panel in 100 wing housekeeping closet was block NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the facility Maintenance Director (MO) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	9.1.2, 1999 NFPA 70, 110-26. 2. The deficient practice could affect 10 out of 40 residents. 3. The Maintenance Director and Environmental Director have been educated on the need to not block the circuit breaker panel. 4. The ED or designee will complete random audits on the area around the circuit breaker panel monthly for three months. Results will be communicated to the QAPI committee.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 7, 2014

Ms. Kaitlin Thomas, Administrator
Golden Livingcenter - La Crescent
101 South Hill Street
La Crescent, Minnesota 55947

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5319023

Dear Ms. Thomas:

The above facility was surveyed on April 14, 2014 through April 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	04/18/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 14, 15, 16, 17 and 18, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to inform the physician of low blood sugar levels timely for 1 of 1 resident (R3) who is diabetic with known history of low blood sugars. Findings include: R3's signed physician's order dated 3/5/14 indicated that the resident was admitted on 3/26/10. According to the physician's progress note dated 3/5/14 resident's diagnoses included: history of hypoglycemia (low blood sugar), Diabetes type 1 (insulin used), end-stage renal disease requiring dialysis, paranoid schizophrenia, seizure disorder, and major depressive disorder. The 30 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 3/28/14 indicated a BIMS (brief interview mental status) score of 15 which indicated that R13's cognition was intact. R3's signed physician orders dated 3/5/14 included: for blood sugars (BS) 60 give GlucoBurst (glucose). Recheck blood sugar in 15-30 minutes. For BS greater (>) 400 give scheduled insulin, if applicable. Recheck BS in 15-30 minutes. Notify MD of BS less than 50 or greater than 500. Another order also stated to give glucose 1 tube gel by mouth for BS 50 and alert medical doctor. May or may not have symptoms of hypoglycemia; Abilify 45 mg daily, Carbamazepine 300 mg twice a day; Lantus (insulin) 15 units subcutaneously (SQ) every day, Novolog (insulin) 8 units SQ at lunch; and Novolog 3 units SQ before meals. Resident also	2 265		

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2 265	Continued From page 4 had orders for a sliding scale insulin (based on blood sugar level set amount of insulin is given) to be given before meals and at bedtime. The electronic vital signs report indicated that on 4/15/14 at 5:30 p.m. R3 had a blood sugar of 37 mg/dl (milligrams per deciliter). The nurse ' s note dated 4/15/14 at 10:32 p.m. indicated that R3 had no insulin this p.m. due to Accucheck low and requiring GlucoBurst for Accucheck of 37 at beginning of shift. There was no documentation that the physician was notified of the low blood sugar. On 4/10/14 at 5:08 R3's blood sugar was 45 and Glucose gel was given by nurse. There was no documentation that the physician was notified of the low blood sugars. On 3/8/14 at 5:15 a.m. R3's blood sugar was 37 mg/dl. According to the communication book used for dialysis there was a documented note on 3/8/14 that R3's blood sugar was 37. Nurse documented that GlucoBurst had been given and that R3 ate a small breakfast and the BS was 186 when rechecked. Lantus insulin had been given. Please make sure she eats. There was no documentation that the physician had been notified. The Assistant Director of Nursing (ADON)-B in an interview on 4/16/14 at 9:30 a.m. stated that R3 had a low blood sugar yesterday, 4/15/14, and that she had looked for a fax that the physician was notified and could not find one. During an interview with physician - D on 4/17/14 at 8:00 a.m. when asked when he would expect to be called for a low blood sugar, he stated typically he would expect to be notified after the treatment for the low blood sugar was done. He stated he didn't know what the current order was and sometimes when they come back from the hospital and the endocrinologist (a physician who specializes in patient/s with diabetes) writes orders and at times it is kind of confusing.	2 265		

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2 265	Continued From page 5 Physician-D stated he would expect that if a resident had a low blood sugar that the nurse would treat it and then he would want to be notified even if the blood sugar had gone up above 50. A policy titled Diabetes Management Guideline, revised 2013, indicated that hypoglycemia was defined as blood glucose less than or equal to 70 mg. Whenever a glucose test indicates hypoglycemia (70 or less) treatment should be provided immediately. Residents with a diagnosis of diabetes have an order for blood glucose monitoring. Medical doctor (MD) notification parameters in place, glucose gel are used for hypoglycemic events. An acute management of diabetic resident guideline indicated that the physician would be notified as directed by blood glucose. Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. Time Period for Correction: twenty-one (21) days.	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with	2 302		

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2 302	Continued From page 6 Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview the facility failed to provide staff training for Alzheimer's and related dementia education. Findings include: Review of the facility information provided from CMS 672 revealed the facility had 19 residents diagnosed with dementia. On 4/15/14, at 3:30 p.m., documentation provided by the director of nursing dated 11/21/13, revealed in-service record topic: communicating with the elderly, dementia, the education lacked information that included explanation of Alzheimer ' s disease and	2 302		

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2 302	Continued From page 7 related disorders, assistance with activities of daily living, problem solving with challenging behaviors. During interview on 4/16/14, at 12:50 p.m., the director of nursing verified the above. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all direct care staff and their supervisors on how to work with persons with dementia type behavior. This should at a minimum include explanation of Alzheimer ' s disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors and communication skills. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop seizure interventions in regards to detecting signs and symptoms of seizures and safety measure to prevent injury and impaired airway on the	2 560		

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2 560	Continued From page 8 comprehensive care plan for one of one resident (R3) who was diagnosed as having seizures. Findings include: R3's comprehensive care plan had not addressed the risk factors and interventions for seizure activity related to hypoglycemia. R3's comprehensive care plan dated 4/22/11 was reviewed and did not address signs or symptoms of seizures, possible adverse side effects of the anti-seizure medicine, to alert care givers of the need to immediately report these signs and symptoms to the nurse and how to protect the resident if they have a seizure. R3's signed physician's order dated 3/5/14 indicated that the resident was admitted on 3/26/10. According to the physician's progress note dated 3/5/14 resident's diagnoses included: history of hypoglycemia (low blood sugar), Diabetes type 1, end-stage renal disease requiring dialysis, paranoid schizophrenia, seizure disorder, and major depressive disorder. R3's signed physician orders dated 3/5/14 indicated that R3 received carbamazepine 300 mg orally twice a day due to having a history of seizures. R3 had been seen in the emergency room due to having seizures a home and R3 was discharged on 2/28/14 and the emergency physician documented the principal diagnosis was seizure due to profound hypoglycemia. The Director of Nursing (DON) on 4/18/14 was unable to provide a specific care plan policy. During a phone call on 4/22/13 the DON stated she did not have a care plan policy. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff responsible for developing care plans to include	2 560		

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2 560	Continued From page 9 all interventions needed for the resident. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow the plan of care for 1 of 1 residents (R3) who had diabetes and had low blood sugars that had not been reported to the doctor according to the plan of care. Findings included: R3's signed physician's order dated 3/5/14, indicated that the resident was admitted on 3/26/10. According to the physician's progress note dated 3/5/14, R3's diagnoses included: history of hypoglycemia (low blood sugar), Diabetes type 1, end-stage renal disease requiring dialysis, paranoid schizophrenia, seizure disorder, and major depressive disorder. The 30 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 3/28/14, indicated a BIMS (brief interview mental status) score of 15 which indicated that R3's cognition was intact. The MDS indicated that R3 required extensive assist with transfers, dressing and toilet	2 565		

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2 565	Continued From page 10 use. R3, interviewed on 4/15/14, at 4:00 p.m., stated she had dialysis on Tuesday, Thursdays and Saturdays. R3 stated that she leaves around 6 a.m., eats breakfast before leaving, and arrives back at the facility for lunch. R3's care plan dated 4/22/11, identifies a problem of alteration in blood glucose due to insulin dependent diabetes mellitus, hyperglycemic (high blood sugar) episodes, and hypoglycemic episodes. The interventions included to observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating, light headedness. Report abnormal results per physician parameters/guideline. The electronic vital signs report indicated that on 4/15/14, at 5:30 p.m. R3 had a blood sugar (BS) of 37 mg/dl (milligrams per deciliter). The nurses note dated 4/15/14, at 10:32 p.m. indicated that R3 had no insulin this p.m. due to Accucheck low and requiring gluco-burst for Accucheck of 37 at beginning of shift. There was no documentation that the physician was notified of the low blood sugar. On 4/10/14 at 5:08 R3's blood sugar was 45. Glucose gel was given by nurse. Again there was no documentation that the physician was notified of the low blood sugar level. On 3/8/14, at 5:15 a.m. R3's blood sugar was 37.0 mg/dl. The dialysis communication book had a note on 3/8/14, that R3's blood sugar was 37. Nurse documented that glucoburst had been given and that R3 ate a small breakfast and the BS was 186 when rechecked. Lantus given. Please make sure she eats. There was no documentation that the physician had been notified. The assistant director of nursing-B was interviewed on 4/16/14, at 9:30 a.m., and stated that R3 had a low blood sugar yesterday, 4/15/14,	2 565		

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2 565	Continued From page 11 and that she had looked for a fax that the physician was notified and could not find one. R3's physician (P)-D, interviewed on 4/16/14 at 9:30 a.m., stated that if it was that low (in reference to BS of 37) they would not have called him at that time but would have called the on call doctor. On 4/17/14 at 8:00 a.m., P-D stated he would expect to be notified after the treatment for the low blood sugar was done. P-D stated he didn't know what the current order was, sometimes when residents come back from the hospital and the endocrinologist writes orders it is kind of confusing. P-D expected to be notified after licensed staff treated the patient's low blood sugar even if the blood sugar had gone up above 50 after being treated. A policy titled Diabetes Management Guideline, revised 2013, indicated that hypoglycemia was defined as blood glucose less than or equal to 70 mg. Whenever a glucose test indicates hypoglycemia treatment should be provided immediately. Residents with a diagnosis of diabetes have an order for blood glucose monitoring. MD notification parameters in place, glucose gel is used for hypoglycemic events. An acute management of diabetic resident guideline indicated that the physician would be notified as directed by blood glucose. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff the need to follow the residents care plan as written. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is	2 685		

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2 685	Continued From page 12 transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to complete a discharge summary and recapitulation of stay for 4 of 5 residents (R61, R53, R67, R2) who were discharged from the facility. Findings include: R61 was admitted on 1/1/14, and discharged home on 1/24/14. Nursing documentation indicated the discharge instructions were discussed and medications sent home with the resident. Family was transporting the resident. The care conference note dated 1/16/14, documented a discharge plan for R61. The interdisciplinary discharge summary dated 1/24/14 indicated R61 was discharged to home, but did not include a recapitulation of stay. No physician discharge orders, discharge summary or recapitulation of the stay was found in the medical record. R53 was admitted on 11/5/13, and discharged on 11/13/13. Nursing notes on 11/13/13 indicated R53 was discharged home with daughter. R53 had signed a discharge summary, denied pain or discomfort and took along a medication list. The interdisciplinary discharge summary dated	2 685		

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2 685	Continued From page 13 11/13/13 did not indicate where the resident was discharged to and did not include a recapitulation of stay. R67 was admitted to the facility on 2/17/14 and discharged on 3/1/14. On 2/28/14 the physician wrote orders that R67 could be discharged to home on current medications. The nursing documentation on 3/1/14, indicated R67 was discharged to home with the family and that the medication orders were faxed to the pharmacy. Nursing documented the resident denied any questions or concerns regarding discharge order. The interdisciplinary discharge summary dated 3/1/14 indicated R67 was admitted on 2/17/14 but did not indicate where she was discharged to and lacked a recapitulation of stay. R2 was admitted to the facility on 3/5/13 and discharged on 3/17/13. Nursing notes of 3/14/14 stated R2 saw the physician at the clinic and could discharge to home. No written order authorizing discharge was found in the medical record. Nursing notes of 3/17/14 documented discharge instructions were reviewed with R2 and a list of the medications was reviewed. R2 verbalized understanding. A list of follow-up medical appointments was provided to R2. On 3/11/14 at the care conference a documented discharge plan was provided to the resident. The Interdisciplinary Discharge Summary dated 3/17/14 stated R2 was admitted from Winona Health and discharged to home. No recapitulation of stay was documented. The director of nursing (DON) interviewed on 4/17/14, at 10:20 a.m., stated there should be a recapitulation of stay for each resident as well as	2 685		

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2 685	Continued From page 14 discharge orders. The DON stated, on 4/17/14 at 11:27 a.m., there was no recapitulation of stay for R61, R53, R67 and R2. The DON also stated there were no written physician discharge orders for R61, R53 and R2. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the need to do a discharge summary as outlined in the regulation/order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 685		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to respond appropriately to episodes of low blood sugar for 1 of 1 residents (R3) who was recently hospitalized for a seizure related to low blood sugar.	2 830		

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2 830	Continued From page 15 Findings included: R3's physician progress note dated 3/5/14, indicated diagnoses that included: history of hypoglycemia (low blood sugar), Diabetes type 1, end-stage renal disease requiring dialysis and seizure disorder. The hospital discharge summary dated 2/28/14, indicated R3 was treated following a seizure due to profound hypoglycemia (low blood sugar) at the facility. The summary indicated that hypoglycemia remained a huge concern and R3's blood glucose should be allowed to run on the higher side. R3's signed physician orders dated 3/5/14 included treatment for hypo/hyperglycemia as follows: For blood sugars (BS) less than 60 give Glycoburst. Recheck blood sugar in 15-30 minutes. For BS greater than 400 give scheduled insulin, if applicable. Recheck BS in 15-30 minutes. Notify MD of BS less than 50 or greater than 500. Another order directed glucose 1 tube gel by mouth for BS 50 and alert MD. May or may not have symptoms of hypoglycemia. The 30 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 3/28/14 indicated a BIMS (brief interview mental status) score of 15 which indicated that R3's cognition was intact. The MDS indicated that R3 required extensive assistance with transfers, dressing and toilet use. R3's care plan dated 4/22/11, included a problem of alteration in blood glucose due to insulin dependent diabetes mellitus, hyperglycemic (high blood sugar) episodes, and hypoglycemic episodes. The interventions included to observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating, light headedness. Report abnormal results per physician parameters/guideline.	2 830		

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	00936	A. BUILDING: _____ B. WING _____	04/18/2014

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2 830	Continued From page 16 The electronic vital signs report indicated that on 4/15/14 at 5:30 p.m. R3 had a blood sugar of 37 mg/dl (milligrams per deciliter). The nurses note dated 4/15/14 at 10:32 p.m. indicated that R3 had no insulin this p.m. due to Accucheck low and requiring Glycoburst for Accucheck of 37 at beginning of shift. There was no documentation that the physician was notified of the low blood sugar. On 4/10/14 at 5:08 p.m. R3's blood sugar was 45. Glucose gel was administered; however, there was no documentation that the physician was notified. On 3/8/14, at 5:15 a.m. R3's blood sugar was 37.0 mg/dl according to the dialysis communication book. Nurse's documentation indicated Glycoburst had been given and that R3 ate a small breakfast and the BS was 186 when rechecked. There was no documentation that the physician had been notified. The assistant director of nursing (ADON)-B, interviewed on 4/16/14 at 9:30 a.m. stated that R3 had a low blood sugar yesterday, 4/15/14, but she could not find any evidence the physician was notified. R3's physician (P)-D, interviewed on 4/16/14 at 9:30 a.m., stated that he or the on-call physician should have been contacted regarding low BS. R3 was interviewed on 4/15/14 at 4:00 p.m. and stated she received dialysis on Tuesday, Thursdays, and Saturdays. R3 stated that she eats breakfast before leaving around 6:00 a.m. and returns before lunch. An interview with the dialysis unit nurse, (RN)-G, on 4/16/14 at 1:04 p.m., indicated R3's BS was not checked unless there were symptoms of hypoglycemia. The primary physician would be the one that monitors R3's blood sugars. During an interview about when to notify the physician of low blood sugars on 4/16/14 at 1:20 p.m., licensed practical nurse (LPN)-B stated R3's orders had been changed that day. If blood	2 830		

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2 830	Continued From page 17 sugar was below 50 they are to give the glycogen and recheck and then call the physician if still below 50 or above 400. LPN-B stated before the change today, she would have called the physician to let him know of the low blood sugar level. On 4/17/14 at 7:00 a.m. the Registered Pharmacist (RP)-C stated that hypoglycemia could be related to R3's other medications, for example the antipsychotic Abilify could cause low blood sugar levels. Physician (P)-D, interviewed on 4/17/14 at 8:00 a.m., stated he would expect that if a resident had a low blood sugar the nurse would treat it and then he would want to be notified even if the blood sugar had gone up above 50. A policy titled Diabetes Management Guideline, revised 2013, indicated that hypoglycemia was defined as blood glucose less than or equal to 70 mg. Whenever a glucose test indicates hypoglycemia treatment should be provided immediately. Residents with a diagnosis of diabetes have an order for blood glucose monitoring. MD notification parameters in place, glucose gel is used for hypoglycemic events. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff on the need to provide cares as needed by the resident. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		

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2 910	Continued From page 18 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess the risk for urinary tract infections (UTIs) for 4 of 4 residents (R59, R71, R11, R45) identified by the facility as utilizing prophylactic antibiotics to prevent UTIs. Findings include: R59 was observed on 4/14/14 at 9:30 a.m. R59 was alert and oriented, reading the newspaper. During an interview on 4/15/14 at 9:27 a.m., R59 stated she was independent with most of her cares. During an interview on 4/18/14 at 9:45 a.m., nursing assistant (NA)-A stated R59 was independent, but that staff would help with perineal care if R59 requested the help. R59's signed physician orders of 3/14/14 included Keflex (antibiotic) 250 mg by mouth at bedtime for prevention of UTI. The physician documentation of 3/5/14 indicated a problem list of chronic bronchitis, history of depression, anxiety, recurrent urinary tract infections and	2 910		

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2 910	Continued From page 19 history of diverticulitis. Physician documentation of 3/6/14 indicated recurrent urinary tract infections. The physician noted R59 did not do well coming off the antibiotic and to continue with current daily antibiotic and monitor for recurring symptoms. Review of the physician documentation of 3/19/14 indicated R59 had a recurrent urinary tract infection, but had no discussion of symptoms of an infection. The bladder assessment form dated 2/3/14 indicated R59 was continent of bladder. There was no documentation of assessment for any physical abnormalities, recent urinalysis or any post void residuals. The assessment form did not evaluate R59's risk to develop urinary tract infections or that she was on Keflex daily prophylactically. No further urinary/bladder assessment or evaluation was found. The admission Minimum Data Set (MDS) dated 2/5/14 indicated R59 had a BIMS (Brief interview of mental status) score of 14 or cognitively intact, required supervision assistance for toileting and hygiene, was continent of urine, had not had a UTI in the past 30 days. No care area assessment (CAA) was completed. The care plan printed 3/15/14 indicated R59 required personal hygiene assistance of one and toileting assistance of one as needed. The care plan indicated a problem of at risk for alteration in elimination of bowel and bladder due to history of UTIs with antibiotic or preventions. Interventions directed to monitor and report signs/symptoms of UTI and to provide assistance of one to toilet and to use briefs/pads for incontinence protection. The director of nursing (DON) was interviewed on 4/18/14 at 9:30 a.m. DON stated R59 had no	2 910		

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2 910	Continued From page 20 urinary tract infections (UTIs) since admission. At 9:40 a.m. DON stated she was not able to find a urinary tract infection risk assessment. R 71 was observed on 4/18/14 at 9:40 a.m. independently utilizing the exercise bike in the therapy room. At 9:44 a.m. on 4/18/14 NA-C stated R71 was mostly independent with perineal cares but required stand by assistance and help as needed. NA-C stated staff set her up for personal hygiene cares and that R71 would ask for help with transfers. R71 was admitted on 4/1/14 and had diagnosis listed on the physician notes of 4/2/14 as peripheral neuropathy, diabetes, recurrent constipation, chronic kidney disease and recurrent urinary tract infections. A urology note dated 2/21/13 stated R71 had a history of recurrent UTI and was on prophylactic antibiotics at bed time. Urology note dated 8/29/13 indicated recurrent UTI and use of prophylactic Trimethoprim (antibiotic) 50 mg at bedtime. Physician orders dated 4/1/14 include Trimethoprim 50 mg by mouth at bedtime for recurrent urinary tract infections. R71 had a temporary care plan in place that did not address recurrent UTIs or assistance needed for toileting and hygiene. A bladder assessment was not found. During an interview on 4/18/14 at 9:10 a.m. the director of nursing stated R71 had been treated for a UTI following admission. At 9:40 a.m. DON stated a urinary tract risk assessment had not been completed. R11 was observed on 4/18/14 at 9:40 a.m. sitting	2 910		

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2 910	Continued From page 21 in the lobby reading a newspaper. NA-C was interviewed at 9:44 a.m. on 4/18/14 and stated R11 required total assistance with perineal cares and required extensive assistance with transfers. R11 was admitted on 12/19/11. Physician notes dated 11/29/12 indicated R11 had a history of chronic urinary tract infections and during a hospitalization had the prophylactic antibiotic discontinued. The 11/29/12 documentation indicated that since the discontinuation of the prophylactic antibiotic R11 had experienced three UTIs and the physician felt a prophylactic antibiotic would be warranted. 11/29/12 urology notes indicated recurrent E.Coli UTI. Physician orders signed 4/16/14 noted Keflex 250 mg by mouth at bed time for urinary tract infection. A bladder assessment dated 8/23/13 indicated R11 was incontinent of bladder but may have some daily control, received diuretics, was on an antidepressant, and had mild dementia. The assessment identified stress urinary incontinence. The form did not indicate R 11 was assessed for any physical abnormalities, and recent urinalysis, or any post void residuals. The assessment form did not evaluate R11's risk to develop urinary tract infections or that she was on Keflex prophylactically. The care area assessment dated 4/18/14 for urinary incontinence noted incontinent of bladder due to nerve damage during past surgery. The quarterly MDS dated 2/21/14 indicated R11 had a BIMS score of 15 or cognitively intact, required extensive assistance with toileting and personal hygiene, was always incontinent and had a UTI in the past 30 days. The care plan printed 3/13/14 identified a problem of physical functioning deficit that directed staff that R11 required assistance of one for personal	2 910		

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2 910	Continued From page 22	2 910		

hygiene and toileting assistance of one to check and change every 2 hours and as needed. The care plan printed 3/13/14 identified a problem of alteration in elimination. Frequent incontinence of bladder with interventions that directed monitor and report signs and symptoms of UTI and provide assistance of one to toilet.
During an interview on 9/24/14 at 9:40 a.m. the DON stated R11 last had a UTI on June 2013 and that a urinary tract infection risk assessment had not been completed. The DON was unsure if R11 had seen a urologist as recommended by the primary physician but would look. No further information was provided.

R45 was observed on 4/18/14 at 9:35 a.m. sitting napping in her wheelchair. During an interview on 4/18/14 at 9:45 a.m. NA-A stated R45 was continent for the most part and would sneak into the bathroom without assistance. Staff were to wash her perineal area after any incontinent episodes.

R45 was admitted on 11/17/12. A physician visit note of 3/5/14 listed diagnoses of chronic kidney disease and incontinence. A physician visit note of 5/2/13 noted R45 was on Ditropan XL (treat overactive bladder) and also taking Trimethoprim for UTI prophylaxis. Physician orders signed 3/5/14 included Trimethoprim 100 mg for UTI at bedtime

The bladder assessment dated 11/14/13 noted incontinence with leakage on way to bathroom frequently. The assessment did not address possible physical abnormalities, recent urinalysis or post void residuals. The assessment did not evaluate R45's risk to develop urinary tract infections or that she was on Trimethoprim daily prophylactically. The care area assessment

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2 910	Continued From page 23 dated 1/27/13 identified R45's incontinence, but did not evaluate the chronic urinary tract infection risk. The quarterly MDS dated 2/14/14 indicated a BIMS score of 6 or severe cognitive impairment, frequent incontinence, assist of one with toilet use and personal hygiene, and no UTIs in the past 30 days. The care plan for physical functioning deficit printed 3/15/14 directed personal hygiene assistance of one and assistance with perineal care at least once each shift. The care plan printed 3/15/14 identified alteration in elimination of bowel and bladder, frequent functional incontinence and directed monitor and report signs and symptoms of UTI. During an interview on 4/18/14 at 9:30 a.m. the DON stated R45's last UTI was in May 2013 and that she was not able to find a UTI risk assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff responsible for urinary incontinence on the need to address all incontinence needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		

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21375	Continued From page 24 by: Based on observation, interview, and record review the facility failed to maintain sanitary procedures during wound dressing change for 1 of 2 residents (R43) reviewed for wound care; failed to implement procedures to prevent the possible spread of infection during blood glucose monitoring observations for 1 of 2 resident (R18) who had blood sugars taken. Findings Include: R43 was observed during a wound dressing change to the foot on 4/16/14 at 10:12 a.m. with licensed practical nurse (LPN)-A. LPN-A used exam gloves to remove the dressing and clean the area with wound cleanser. LPN removed her gloves and went to the supply cupboard to obtain an opened box of tubular gauze which she sat on R43's over the bed table. LPN-A put on clean gloves and applied a new dressing. LPN-A applied a sterile telpha pad to the area with her right hand. She then took tube gauze that was sitting on the over bed table out of the box with her right hand, cut the gauze with a scissors from her pocket using her left hand and returned the roll of tube gauze to the table. She applied the tube gauze to R43's foot. After removing her gloves, LPN-A placed the roll of tube gauze into the box and stated she was going to take it back to the storage closet. The director of nursing (DON) was interviewed on 4/16/14 at 10:30 a.m. DON stated the tubular gauze should not have been opened and in the storage closet. DON stated only sealed dressing were to be kept in the storage closet. If a dressing was to used for the resident, that dressing should be kept with the other treatments in the cart. The DON stated the dressings were	21375		

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21375	Continued From page 25 now contaminated. R18 had blood drawn on 4/16/14, at 7:25 a.m., for a blood glucose level. Registered nurse (RN)-A was observed to check R18's blood sugar during which RN-A had gloves on and had removed and discarded the used blood glucose strip sticking out of the glucometer (which had visible blood on end of strip sticking out of the glucometer) into a sharps container hanging on R18' s room door. RN-A had then carried the glucometer out into the hallway to the medication cart, laid the glucometer on the medication cart (glucometer had not been cleaned), removed gloves, washed hands and proceeded to start setting up to pass medications. Surveyor intervened and verified at the time with RN-A the glucometer had not been cleaned. RN-A had stated, I won't clean it until I put it away." RN-A stated only one glucometer for each medication cart, the glucometer is shared between residents and had stated uses an alcohol pad to clean the glucometer. RN-A had proceeded to pick up the glucometer without gloves on and clean the glucometer with an alcohol pad. RN-A verified at the time had no gloves on when cleaning the glucometer and had used an alcohol pad to clean the glucometer. However, the glucometer had not been sanitized with a product recommended to kill blood bourne diseases. During interview on 4/16/14, at 1:00 p.m., director of nursing had stated she would expect policy to be followed and use wipe for cleansing for one full minute as policy states for cleaning the glucometer and gloves are to be worn when cleaning the glucometer. Document review of facility policy GLUCOMETER DECONTAMINATION dated 12/2/13, read	21375		

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21375	Continued From page 26 "PURPOSE: To implement a safe and effective process for decontaminating glucometers. Dispatch wipes will be used as a Glucometer disinfectant. This is EPA registered as tuberculocidal; effective against HIV, HBV, and a broad spectrum of bacteria. It is hypochlorite based and meets recommendations for use on equipment for Clostridium difficile rooms. If Dispatch is not available, a 1:10 bleach solution may be substituted. POLICY: The glucometer will be decontaminated with a Dispatch wipe following use on each resident. Gloves will be worn and the manufacturer's recommendations will be followed. Procedure: I. The nurse will obtain the glucometer along with the dispatch wipes and place the glucometer on the over bed table on a clean surface. II. After performing the glucometer testing, the nurse, wearing gloves, will use a dispatch wipe to wipe all external parts of the glucometer. III. The clean glucometer will be placed on another paper towel. IV. Gloves will be removed and hand hygiene performed. V. The glucometer will be placed in the medication cart or other clean storage area until needed." SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff on the basic principles of infection control to prevent the spread of infection/s. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most	21426		

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21426	Continued From page 27 current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a Tuberculosis (TB) risk assessment according to the current Centers for Disease Control (CDC) guidelines for preventing the transmission of Tuberculosis and the facility failed to ensure screening of active tuberculin symptoms and tuberculosis testing was completed upon admission for 2 of 5 residents (R3, R43) and 2 of 5 employees registered nurse (RN)- A and licensed social worker (LSW)-A. R43 had been admitted to the facility 11/14/2011 according to the face sheet. A tuberculosis screening was not evident in the medical record and there was no evidence documented that R43 had received the tuberculin skin test (TST). R3 had been admitted to the facility 3/26/10 according to the signed physician orders dated	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	04/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21426	Continued From page 28 3/5/14. A tuberculosis screening was not evident in the medical record and there was no evidence documented that R8 had received the tuberculin skin test (TST). RN-A had a hire date of 9/25/13. Document review of facility employee tuberculin skin test records revealed lack of evidence of tuberculin skin test administered for RN-A or previously received before hire date. LSW-A had a hire date of 5/1/13. Document review of facility employee tuberculin skin test records revealed lack of evidence of tuberculin skin test administered for LSW-A or previously received before hire date. During an interview with the Director of Nursing (DON) on 4/18/14 9:49 a.m. documentation was requested for 5 staff and 5 residents for documentation of tuberculin testing. The DON confirmed that 2 of the 5 employees and 2 of the 5 residents did not have documentation that tuberculosis testing had been completed. The DON was unable to provide a Risk Assessment on 4/18/14 when asked and then on 4/22/14 at 2:52 p.m. the DON stated she could not find the documentation that a TB Risk Assessment was completed. The policy titled Tuberculosis Exposure Control Plan, guidelines for skin testing for admissions and new hires dated 1998 indicated that all new admissions, new associates, and volunteers receive a 2-step Mantoux PPD Test (.1 ml of 5 tuberculin units-interdermally)- unless they have a documented past positive PPD. Step 1 was to be administered on admission/or on hire. Under Method of Compliance, it indicated that the following measure would be implemented: conducting risk assessment (baseline and periodic) all activity of the control plan is as a	21426		

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21426	Continued From page 29 result of the risk assessment category). SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff responsible for TB on the most current standards and requirements in regards to TB control. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must	21530		

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	00936	A. BUILDING: _____ B. WING _____	04/18/2014

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21530	Continued From page 30 refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacy consultant identified lack of parameters for as needed pain medications for 1 of 5 residents (R56) and failed to identify lack of monitoring 2 of 5 residents (R19, R8) for psychotropic medications reviewed for unnecessary medications. Findings include: R56 was admitted on 11/18/13. Physician orders dated 3/28/14, identified diagnoses that included closed fracture part neck femur, malignant neoplasm of breast, anxiety state and depressive disorder. The quarterly Minimum Data Set (MDS) dated 2/17/14, identified brief interview of mental status (BIMS) had been 12 out of 15 and indicated moderate cognitive impairment. R56 had near constant pain rated eight on the scale of one to ten and no behaviors. R56 received scheduled pain medication, PRN (as needed) medication and non-medication interventions for pain.	21530		

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21530	Continued From page 31 R56's current physician orders dated 3/38/14, revealed an order for lorazepam (Ativan) (an anti-anxiety medication) 0.5 mg (milligrams) every eight hours as needed (PRN) for anxiety, oxycodone-acetaminophen (a pain medication) 5-325 mg one to two tabs every four hours PRN for pain, do not exceed 12 tablets per day (no indication on physician orders identified when to give one tablet or two tablets) and Tylenol (a pain medication) 650 mg once a day at HS (bedtime) PRN for pain. During review of R56's medication administration records the following had been noted: from the dates of 3/17/14 through 3/31/14 R56 had had received a total of 18 doses of PRN lorazepam, 35 doses of PRN oxycodone-acetaminophen, 3 doses of PRN Tylenol and from the dates of 4/1/14 through 4/16/14 R56 had received 14 doses of PRN lorazepam, 24 doses of PRN oxycodone-acetaminophen, one dose of PRN Tylenol. R56's progress notes dated 3/17/14 through 4/16/14 identified the use of the Ativan was not clearly identified as to parameters to why it was given. During interview on 4/17/14, at 2:25 p.m., Assistant director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. During interview on 4/17/14, at 2:59 p.m., Director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. On 4/17/14, at 3:52 p.m., director of nursing state she would expect consultant pharmacist to have identified parameters and non-pharmacological measure concerns.	21530		

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21530	Continued From page 32 Document review of the facility policy controlled substance prescriptions dated revised 11/11, read " Procedures A. Elements of controlled substance prescription: 13) PRN (as needed) orders clearly delineate the condition for which they are being administered, for example, " as needed for severe pain (pain scale 7-10), " or " as needed for sleep. " Facility director of nursing provided only page one of four of policy. R19's received Celexa an antidepressant without identified mood symptoms to monitor if it was effective or not. R19's physician orders dated 4/16/14 indicated that R19 was admitted on 7/11/13 with diagnoses including, but not limited to: delusional disorder, dementia with behavioral disturbance, anxiety state, generalized pain and chronic kidney disease state III (moderate). The quarterly Minimal Data Set (MDS) dated 3/12/14 indicated that R19's BIMS (brief interview mental status) was 9 out of 15 indicating cognitively moderately impaired. During the review of R19's physician orders dated 4/16/14 it was indicated that R19 received Celexa 10 mg one time a day for anxiety state. R19's comprehensive care plan dated 7/24/13 indicated a problem that R19 was receiving an antidepressant medication and that R19 had the potential to show signs and symptoms of mood concerns. The goal indicated that R19 would talk about positive topics and happy memories during conversations. Interventions included: encourage to get involved in activities related to interests, help keep in contact with family and friends, to give medications that help with depression and manage any side effects, and to take the time to discuss feelings when feeling	21530		

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21530	Continued From page 33	21530		

sad. A second problem dated 8/2/13 indicated that there was a potential for drug related complications associated with the use of psychotropic medications related to antidepressant medication. Interventions included to assess for pain, monitor for side effects and report to physician, monitor for signs/symptoms of depression including isolating self to room, making negative statements and document. Report changes to physician. Monthly pharmacy review of medication regimen. Provide non-pharmaceutical interventions of visits with family and friends, attending activities like bingo and music programs, resting in recliner with feet up. To decrease target behaviors, anxiety or depression.

During observation and interview with R19 on 4/16/14 at 7:29 a.m. resident was observed walking out of the bathroom with a nursing assistant. R19 stated it's better once she gets up and moving around. During observation on 4/16/14 at 8:13 a.m. R19 was out in the dining room and was observed laughing and conversing with her tablemates and the administrator.

An interview with nursing assistant (NA)-D on 4/17/14 at 1:08 p.m., when asked how R19 displayed her anxiousness or mood, NA-D stated that she would get very upset about her whirlpool and not wanting to get her hair ruined. There were no comments about mood or symptoms associated with it.

During an interview with LPN-A on 4/17/14 at 2:15 p.m. when asked about R19's behaviors or moods, LPN-A stated that she didn't know what the hallucinations were, and LPN-A stated that she was unclear what R19's symptoms were for the use of the antidepressant.

During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that R19 was recently hospitalized for a

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21530	Continued From page 34	21530		

delusional disorder. For R19's depression, the DON stated that R19 would not come out of her room.
A review of the behavior monthly flow sheet for February, April and March of 2014, indicated that depressed withdrawn and hallucinations/paranoia/delusion was the behavior code. Mood changes were not being monitored. Documentation indicated no behaviors observed except one time in February 2014 for depressed/withdrawn with no individualized mood indicator.
The quarterly interdisciplinary resident review dated 3/12/14 under behavioral symptoms indicated none, with the use of an antidepressant. Marked anxious at times, with no individual or quantitative behavior documented.
No policy on targeted behaviors were provided after being requested on 4/18/14.

R8 received an antidepressant medication yet there were no clear mood symptoms/signs specific to this resident identified to determine if the antidepressant was affective or not.
R8's physician orders dated 4/1/14 indicated that R8 was admitted on 11/26/05 with diagnoses including: senile dementia, hemiplegia, depressive disorder, and generalized anxiety disorder.
The quarter MDS dated 3/20/14 indicated R8's BIMS score was 9 out of 15 which indicated cognition was moderately impaired.
The physician's order dated 4/1/14 indicated that R8 was receiving Zoloft 50 mg every day for depressive disorder.
The comprehensive care plan dated 5/21/11 had a problem of R8 feeling sad and restless, irritable, lonely, angry. No mood behaviors were identified.
During an interview with R8 on 4/16/14 at 7:05

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21530	Continued From page 35 a.m., resident was waiting for breakfast in room while watching TV R8 stated her appetite was pretty good and she didn't really like watching TV During observation on 4/16/14 at 8:09 a.m. while R8 was in the dining room at a table by self, no behaviors of yelling out were observed. A review of the behavior monthly flow sheet for February, March, and April of 2014 indicated that R8's behavior code was angry and continuous screaming/yelling. No individualized mood changes were identified. During an interview with nursing assistant (NA)-D when asked how R8 displays mood changes, NA-D stated that R8 is attention-seeking, yells out, and is irritable but had no comments about symptoms associated with depression. During an interview with (LPN)-A, when asked about how R8 displays mood behaviors LPN-A stated that she had never seen R8 scream or yell out and did not know any identified mood behaviors. During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that a long time ago R8 had sexually inappropriate behaviors and has some issues with yelling out. There was no monitoring of mood. SUGGESTED METHOD OF CORRECTION: The pharmacist or director of nursing could read the requirements for the use of a psychoactive medication. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		

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21535	Continued From page 36 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify, assess and monitor clinical indications for use of psychoactive medications for 3 of 5 residents (R56, R19, R8) reviewed for unnecessary medications. Findings include: R56 was admitted on 11/18/13. Physician orders dated 3/28/14, identified diagnoses that included closed fracture part neck femur, malignant neoplasm of breast, anxiety state and depressive disorder. The quarterly Minimum Data Set (MDS)	21535		

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21535	Continued From page 37 dated 2/17/14, identified brief interview of mental status (BIMS) had been 12 out of 15 and indicated moderate cognitive impairment. R56 had near constant pain rated eight on the scale of one to ten and no behaviors. R56 received scheduled pain medication, PRN (as needed) medication and non-medication interventions for pain. R56's current physician orders dated 3/38/14, revealed an order for lorazepam (Ativan) (an anti-anxiety medication) 0.5 mg (milligrams) every eight hours as needed (PRN) for anxiety, oxycodone-acetaminophen (a pain medication) 5-325 mg one to two tabs every four hours PRN for pain, do not exceed 12 tablets per day (no indication on physician orders identified when to give one tablet or two tablets) and Tylenol (a pain medication) 650 mg once a day at HS (bedtime) PRN for pain. During review of R56's medication administration records the following had been noted: from the dates of 3/17/14 through 3/31/14 R56 had had received a total of 18 doses of PRN lorazepam, 35 doses of PRN oxycodone-acetaminophen, 3 doses of PRN Tylenol and from the dates of 4/1/14 through 4/16/14 R56 had received 14 doses of PRN lorazepam, 24 doses of PRN oxycodone-acetaminophen, one dose of PRN Tylenol. R56's progress notes dated 3/17/14 through 4/16/14 identified the use of the Ativan was not clearly identified as to parameters to why it was given. During interview on 4/17/14, at 2:25 p.m., Assistant director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets.	21535		

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21535	Continued From page 38 During interview on 4/17/14, at 2:59 p.m., Director of nursing verified R56's physician orders lacked parameters for PRN oxycodone-acetaminophen of when to give one or two tablets. On 4/17/14, at 3:52 p.m., director of nursing state she would expect consultant pharmacist to have identified parameters and non-pharmacological measure concerns. Document review of the facility policy controlled substance prescriptions dated revised 11/11, read " Procedures A. Elements of controlled substance prescription: 13) PRN (as needed) orders clearly delineate the condition for which they are being administered, for example, " as needed for severe pain (pain scale 7-10), " or " as needed for sleep. " Facility director of nursing provided only page one of four of policy. R19's received Celexa an antidepressant without identified mood symptoms to monitor if it was effective or not. R19's physician orders dated 4/16/14 indicated that R19 was admitted on 7/11/13 with diagnoses including, but not limited to: delusional disorder, dementia with behavioral disturbance, anxiety state, generalized pain and chronic kidney disease state III (moderate). The quarterly Minimal Data Set (MDS) dated 3/12/14 indicated that R19's BIMS (brief interview mental status) was 9 out of 15 indicating cognitively moderately impaired. During the review of R19's physician orders dated 4/16/14 it was indicated that R19 received Celexa 10 mg one time a day for anxiety state. R19's comprehensive care plan dated 7/24/13 indicated a problem that R19 was receiving an antidepressant medication and that R19 had the potential to show signs and symptoms of mood	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21535	Continued From page 39 concerns. The goal indicated that R19 would talk about positive topics and happy memories during conversations. Interventions included: encourage to get involved in activities related to interests, help keep in contact with family and friends, to give medications that help with depression and manage any side effects, and to take the time to discuss feelings when feeling sad. A second problem dated 8/2/13 indicated that there was a potential for drug related complications associated with the use of psychotropic medications related to antidepressant medication. Interventions included to assess for pain, monitor for side effects and report to physician, monitor for signs/symptoms of depression including isolating self to room, making negative statements and document. Report changes to physician. Monthly pharmacy review of medication regimen. Provide non-pharmaceutical interventions of visits with family and friends, attending activities like bingo and music programs, resting in recliner with feet up. To decrease target behaviors, anxiety or depression. During observation and interview with R19 on 4/16/14 at 7:29 a.m. resident was observed walking out of the bathroom with a nursing assistant. R19 stated it's better once she gets up and moving around. During observation on 4/16/14 at 8:13 a.m. R19 was out in the dining room and was observed laughing and conversing with her tablemates and the administrator. An interview with nursing assistant (NA)-D on 4/17/14 at 1:08 p.m., when asked how R19 displayed her anxiousness or mood, NA-D stated that she would get very upset about her whirlpool and not wanting to get her hair ruined. There were no comments about mood or symptoms associated with it. During an interview with LPN-A on 4/17/14 at 2:15	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	04/18/2014

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21535	Continued From page 40 p.m. when asked about R19's behaviors or moods, LPN-A stated that she didn't know what the hallucinations were, and LPN-A stated that she was unclear what R19's symptoms were for the use of the antidepressant. During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that R19 was recently hospitalized for a delusional disorder. For R19's depression, the DON stated that R19 would not come out of her room. A review of the behavior monthly flow sheet for February, April and March of 2014, indicated that depressed withdrawn and hallucinations/paranoia/delusion was the behavior code. Mood changes were not being monitored. Documentation indicated no behaviors observed except one time in February 2014 for depressed/withdrawn with no individualized mood indicator. The quarterly interdisciplinary resident review dated 3/12/14 under behavioral symptoms indicated none, with the use of an antidepressant. Marked anxious at times, with no individual or quantitative behavior documented. No policy on targeted behaviors were provided after being requested on 4/18/14. R8 received an antidepressant medication yet there were no clear mood symptoms/signs specific to this resident identified to determine if the antidepressant was affective or not. R8's physician orders dated 4/1/14 indicated that R8 was admitted on 11/26/05 with diagnoses including: senile dementia, hemiplegia, depressive disorder, and generalized anxiety disorder. The quarter MDS dated 3/20/14 indicated R8's BIMS score was 9 out of 15 which indicated cognition was moderately impaired.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	04/18/2014

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21535	Continued From page 41 The physician's order dated 4/1/14 indicated that R8 was receiving Zoloft 50 mg every day for depressive disorder. The comprehensive care plan dated 5/21/11 had a problem of R8 feeling sad and restless, irritable, lonely, angry. No mood behaviors were identified. During an interview with R8 on 4/16/14 at 7:05 a.m., resident was waiting for breakfast in room while watching TV R8 stated her appetite was pretty good and she didn't really like watching TV During observation on 4/16/14 at 8:09 a.m. while R8 was in the dining room at a table by self, no behaviors of yelling out were observed. A review of the behavior monthly flow sheet for February, March, and April of 2014 indicated that R8's behavior code was angry and continuous screaming/yelling. No individualized mood changes were identified. During an interview with nursing assistant (NA)-D when asked how R8 displays mood changes, NA-D stated that R8 is attention-seeking, yells out, and is irritable but had no comments about symptoms associated with depression. During an interview with (LPN)-A, when asked about how R8 displays mood behaviors LPN-A stated that she had never seen R8 scream or yell out and did not know any identified mood behaviors. During an interview with the Director of Nursing (DON) on 4/17/14 at 2:30 p.m., the DON stated that a long time ago R8 had sexually inappropriate behaviors and has some issues with yelling out. There was no monitoring of mood. SUGGESTED METHOD OF CORRECTION: The director of nursing/pharmacist could inservice all nurses responsible for medication assessments on the requirements for use of an	21535		

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21535	Continued From page 42 psychoactive medication. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure that narcotics in the emergency kit were stored properly in 1 of 1 medication rooms and failed to ensure expired medication was not available for use for 1 of 1 residents (R12). During the tour of the medication storage room it was observed that the emergency kit which contained narcotics were stored under a single secure lock only and are to be stored in separately locked, permanently affixed compartments, except when the facility uses single unit medication distribution systems in which the quantity stored is minimal and a missing dose can be readily detected; and controlled medications are reconciled accurately. On 4/17/14 at 3:12 p.m. during the medication room storage tour it was noted that the emergency kit had a tag on it but was not locked	21615		

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21615	Continued From page 43	21615		

secured except by the lock on the door to the storage room. This was confirmed by registered nurse (RN)-B.

The Director of Nursing (DON) on 4/17/14 at 3:33 p.m. confirmed this and also confirmed that the following was in the emergency kit: Diazepam Injection 5 mg/ml (Valium) 1- 10 ml vial. Hydrocodone/Apap 5/325 mg (Lortab)12 tablets. Lorazepam 0.5 mg (Ativan), Morphine Sulfate 20 mg/ml 1 30 ml vial, and oxycodone 5 mg, 12 tablets.

A policy titled Controlled Substance Storage dated 05/12 indicated that schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications or per state regulation.

On 4/17/14 at 3:12 p.m. during the review of the 100 Wing cart with RN)B it was noted that a bottle of nitroglycerin tablets had the seal broken and ready for use for R12. This was undated as to when it was opened and it had been filled on 12/31/12 through Health Direct Pharmacy. The expiration date was 4/2013. RN-B stated that she thought that R12 had brought them in upon admission. RN-B confirmed that these were expired and did not have the date on it when it had been opened.

The physician order's dated 3/19/14 indicated that R12 was admitted on 11/11/13 with diagnoses including senile dementia, chronic ischemic heart disease, anxiety state, depressive disorder, esophageal reflux, and paralysis agitans. The quarterly Minimum Data Set (MDS) dated 2/18/14 indicated her BIMS (Brief Interview for Mental Status) was a score of 9 out of 15 indicating

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21615	Continued From page 44 moderately impaired cognition. A signed standing orders dated 11/12/13 indicated that R12 could receive nitroglycerin 1/150 (0.4 mg) sublingual (SL) as necessary for chest pain. May repeat x 2 at 5-minute intervals. When discussed with the DON on 4/17/14 at 3:33 p.m. after the tour of the medication room and a policy requested, the DON provided the CQI Process Example: Medication Storage dated 05/12. This process had a check off list that included that expired, deteriorated or contaminated medications are properly identified, removed from the medication cart, stored and disposed of properly. It also indicated that schedule II medications are maintained in double-locked storage with restricted access. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff responsible for medication storage the need to follow guidelines for class two medication storage requirements. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21615		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure faucets were clear of calcification	21665		

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21665	Continued From page 45 build up on bathroom faucets to promote a sanitized able surface for 3 of 5 bathrooms whose faucets were coated with calcification build-up. Findings include: An observation on 4/14/14 at 6:10 p.m. indicated that bathroom faucets in rooms 104, 205, and 209, had calcification of lime built up around spigot and knobs. An interview on 4/14/14 at 6:10 p.m. with Maintenance-A verified the faucets were lime covered and felt that they would need to be replaced. Maintenance-A stated they have hard water and only the warm water is softened. During an environmental tour with (maintenance) - D, on 4/17/14 at 9:15 a.m. maintenance-D indicated that the spigot and knobs on the sink in room 209 had been replaced. Maintenance-D confirmed that room 104 in the bathroom had the faucet with lime covered and the screws holding the sink onto the walls were uncovered. And that in room 205 the bathroom sink faucet at the end of the spigot had thick lime built up and that the turn knobs were pitted. SUGGESTED METHOD OF CORRECTION: The maintenance department could include a visual inspection of faucets house wide to determine if lime build up is present and then decide how to treat. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		

Name of Facility **2000 CODE**

Golden Living Center - La Crescent

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067	A waiver is requested for K067 for the following reasons: A. There will be no adverse effects on the health and safety of the facility's residents and staff since: 1. The building is equipped with an approved corridor smoke detection system. 2. The building has automatic shut down of ventilation fans/HVAC system upon detection of smoke or activation of the building fire alarm system. 3. Annual service and maintenance contracts exist to service all the facility's fire protection systems (for example; fire alarm, sprinkler system, portable extinguishers) 4. The building fire alarm system is monitored to provide automatic fire department notification. 5. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 6. Fire drills are conducted at least quarterly on each shift. 7. The facility is protected by a supervised automatic sprinkler system. B. Compliance with this provision would impose an unreasonable hardship on the facility since: 1. It would cost an estimated $ 188,000 to upgrade the facility's HVAC system to comply with the NFPA 90A. This figure does not include upgrading the facility's electrical system to accommodate the HVAC equipment C. This tag was previously sited and recommendations were reviewed. A waiver for this tag is requested.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 5-23-14

RON HAMMES REFRIGERATION, INC.

2424 SOUTH AVENUE
LA CROSSE, WI 54601
(608) 788-3110
(608) 788-0563 Fax

PROPOSAL NoGLC12.20.11

Submitted To:
Golden Living Center
101 So. Hill Street
La Crescent, MN 55947

Phone:
507-895-4445

Date:
December 20th, 2011
Revs. 1 5.20.14

Job Location: Corridor ductwork project

WE RESPECTFULLY SUBMIT THE FOLLOWING SPECIFICATIONS AND ESTIMATE FOR:

Fabricate & install all necessary supply & return ductwork thru corridors to provide for dedicated supply & return for current code requirements. Installation would include the following:

- Removal and disposal of existing supply ductwork & diffusers past fire doors
- Fabricate and install new supply ductwork with new ceiling diffusers
- Seal all traverse joints with approved sealant
- Provide insulation as per code for R-value to reduce condensation
- Fabricate & install new return ductwork with new ceiling grilles for balanced airflow
- Provide (1) return thru fire wall with the use of a fire damper for each resident room
- Clean up of all work areas, removal of job related debris
- State and local taxes and applicable permit fees are included within quote

Total Investment $213,624.00

Please Note: Quote does NOT include removal, moving, or re-installation of ceiling grid or tiles, electrical wiring, control wiring, plumbing piping, fire suppression lines, control wiring of resident bath fans for termination upon fire suppression alarm or any other obstructions not listed here within. These would all need to be moved before project is to begin

Please Note: Current HVAC unit meets Fire Protection shut down as per protocol.

WE OFFER TO FURNISH MATERIALS AND LABOR AND COMPLETE THE ABOVE IN ACCORDANCE WITH ABOVE SPECIFICATIONS FOR THE SUM OF: One hundred twenty seven thousand four hundred thirty three dollars and no/100

PAYMENT TO BE MADE AS FOLLOWS: Progress payments due as job progresses with the balance due Net 30 days upon completion, if not paid within terms, finance charges shall accumulate on unpaid balance at 1.5% per month.

AUTHORIZED SIGNATURE_____

Offer may be withdrawn if not accepted within 30 days

All material is guaranteed to be as specified. All work to be completed in a workmanlike manner according to standard practices. Any alteration or deviation from above specifications involving extra costs will be executed only upon written orders, and will become an extra charge over and above the estimate. All agreements contingent upon strikes, accidents or delays beyond our control. Owner to carry fire, tornado, and other necessary insurance. Our workers are fully covered by workmen's compensation insurance.

The above prices, specifications, and conditions are satisfactory and are hereby accepted. You are authorized to do the work as specified. Payment will be made as outlined above.

PURCHASER'S SIGNATURE DATE OF ACCEPTANCE