#### 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. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) GOLDEN LIVINGCENTER - LA CRESCENT (L1)2. Recertification 1. Initial (L4) 101 SOUTH HILL STREET 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55947 (L2)486728900 (L5) LA CRESCENT, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 02 7. PROVIDER/SUPPLIER CATEGORY (L7)8. Full Survey After Complaint (L9) 04/01/2006 01 Hospital **05 HHA** 09 ESRD **13 PTIP** 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 6 DATE OF SURVEY 06/02/2014 (L34)14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP **12 RHC** 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: A. In Compliance With From (a): 2. Technical Personnel Program Requirements 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN \_7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 45 (L18) \_1. Acceptable POC 8. Patient Room Size \_\_\_ 9. Beds/Room 5. Life Safety Code Not in Compliance with Program 45 (L17) 13. Total Certified Beds (L12) Requirements and/or Applied Waivers: \* Code: A,5 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18/19 SNF ICE IID (L15)18 SNF 19 SNF 1861 (e) (1) or 1861 (j) (1): 45 (L37)(L38)(L39)(L42)(L43)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: 18. STATE SURVEY AGENCY APPROVAL Date: 6/10/2014 Gary Nederhoff, Unit Supervisor Kamala Fiske-Downing, Enforcement Specialist 06/10/2014 (L19)(L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: Facility is Eligible to Participate 3. Both of the Above: 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) OF PARTICIPATION REGINNING DATE ENDING DATE **VOLUNTARY** 00 INVOLUNTARY 07/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (1.24)(1.41)(L25) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44)(1.27)B. Rescind Suspension Date: 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00454 (L28) (L31)

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31 RO RECEIPT OF CMS-1539



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.

Golden Livingcenter - La Crescent June 10, 2014 Page 2

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Licensing and Certification File



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, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245319	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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
		Correction			Correction					Correction
ID Prefix	F0157	Completed 05/28/2014		F0279	Completed <b>05/28/2014</b>		ID Prefix	F0282		Completed 05/28/2014
	483.10(b)(11)			483.20(d), 483.20(k)(1)	_			483.20(k)(3)(ii)		
LSC		<del></del>	LSC		=		LSC			_
		Correction			Correction					Correction
ID Prefix	F0283	Completed 05/28/2014		F0309	Completed <b>05/28/2014</b>		ID Prefix	F0315		Completed <b>05/28/2014</b>
	483.20(I)(1)&(2)			483.25				483.25(d)		
LSC			LSC		<del>-</del> -					<del></del> <del></del>
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	F0329	05/28/2014	ID Prefix	F0428	05/28/2014		ID Prefix	F0431		05/28/2014
Reg. # LSC	483.25(I)		Reg. # LSC	483.60(c)	=		Reg. #	483.60(b), (d),	(e)	
	-					-				<u> </u>
		Correction			Correction					Correction
ID Prefix	F0441	Completed 05/28/2014		F0465	Completed 05/28/2014		ID Prefix			Completed
Reg. #				483.70(h)	_					
LSC					_ _		LSC			 _
		Correction			Correction					Correction
		Completed	l		Completed					Completed
					_					
Reg. # LSC			Reg. # LSC		=		Reg. # LSC			
	-									
Reviewed E	By Re	viewed By	Date:	Signature of Su	rveyor:				Date:	
State Agen	су	GN/KFD	06/10/2	014		-	10160			06/02/2014
Reviewed E	ByRe	viewed By	Date:	Signature of Su	rveyor:				Date:	
Followup t	o Survey Comple	eted on:		Check for any Unco	rrected Defi	cienci	es. Was a	Summary of		
	4/18/20	14		Uncorrected Defi					YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245319	(Y2) Multiple Con A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 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) [	ate	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Com	ection pleted 8/2014	ID Prefix		Correction Completed		ID Prefix		Correction Completed
	NFPA 101			Reg. #						
LSC	K0147			LSC		•		LSC		
		Corr	ection			Correction				Correction
			pleted			Completed				Completed
ID Prefix				ID Prefix		-		ID Prefix		
Reg. # LSC				Reg. # LSC				Reg. # LSC		
								-		
			ection			Correction				Correction
ID Prefix		Com	pleted	ID Prefix		Completed		ID Prefix		Completed
Reg. #				<b>.</b> "				Reg. #		
LSC										
		Corr	ection			Correction				Correction
			pleted			Completed				Completed
ID Prefix						:				
Reg. # LSC				Reg. # LSC				Reg. #		
				L3C				LSC		
		Corr	ection			Correction				Correction
ID Prefix			pleted	ID Prefix		Completed		ID Prefix		Completed
Reg. #				D #				Reg. #		
								LSC _		
Reviewed E	By Re	viewed By		Date:	Signature of Sur	veyor:			Dat	e:
State Agen	су	PS/KFD		06/10/2014	:	25	5822			05/31/2014
Reviewed E	By Re	viewed By		Date:	Signature of Sur	veyor:			Dat	e:
Followup t	o Survey Compl 4/17/20				Check for any Uncor Uncorrected Defic	rrected Deficiencies (CN	cienci	es. Was a 67) Sent to	Summary of the Facility?	S NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 11K9

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARI I -	TO BE COMPI	TETED BY 1	THE STA	IE SURVET AGENCY		Facility ID: 00936	
MEDICARE/MEDICAID PROVIDE     (L1) 245319	R NO.	3. NAME AND AI (L3) <b>GOLDEN L</b>	IVINGCENT	ER - LA C	RESCENT	4. TYPE OF ACTI	ON: <u>2 (L8)</u> 2. Recertification	
2.STATE VENDOR OR MEDICAID N	Ο.	(L4) 101 SOUTH	HILL STREE	ET		3. Termination	4. CHOW	
(L2) <b>486728900</b>		(L5) LA CRESCI	ENT, MN		(L6) <b>55947</b>	5. Validation 7. On-Site Visit	<ul><li>6. Complaint</li><li>9. Other</li></ul>	
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>02</u> (L7)	8. Full Survey Aft	on Complaint	
(L9) <b>04/01/2006</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Art	er Compianit	
6. DATE OF SURVEY <b>04/18/</b>	<b>2014</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	UNIC DATE: (L25)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	D 15 ASC		OING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:				
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Require	ments:	
To (b):			equirements		2. Technical Personnel	_ 6. Scope of S	ervices Limit	
10 7 . 17 . 7 . 1	.=	•	e Based On:		3. 24 Hour RN	7. Medical D		
12.Total Facility Beds	<b>45</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN X 5. Life Safety Code	NF) 8. Patient Ro 9. Beds/Roo		
13. Total Certified Beds  45 (L17)  B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B5					9. Beds/R00. (L12)	III		
14 LTC CEPTIEED BED BREAKDON	VNI	1						
14. LTC CERTIFIED BED BREAKDOV	VIN				15. FACILITY MEETS			
18 SNF 18/19 SNF 45	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Gail Sorensen, HFE NE II			04/18/2014	(L19)	Kamala Fiske-Downing, Enforcement Specialist 06/10/2014 (L20)			
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	, ,	
19. DETERMINATION OF ELIGIBILI	TY		IPLIANCE WITI	H CIVIL	Statement of Financial Solvency (HCFA-2572)     Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
1. Facility is Eligible to Pa	rticipate	RIGH	HTS ACT:		3. Both of the Above		II (HCFA-1515)	
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	<u>INTARY</u>	
07/01/1986					01-Merger, Closure		Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provi	der Status Change	
(L27)	B. Rescind St	uspension Date:	(L44)			00-Activ	e	
		•	(L45)					
28. TERMINATION DATE:	29	O. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		00454						
	(L28)			(L31)	AW K67 Emailed	CMS 06/11/2	014 CO.	
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

**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.



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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Gary Nederhoff, 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

Golden Livingcenter - La Crescent May 7, 2014 Page 5

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\_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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Golden Livingcenter - La Crescent May 7, 2014 Page 6

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

PRINTED: 05/20/2014 FORM APPROVED OMB NO. 0938-0391

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	A CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN		FO	000			
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 157 SS=D	on-site revisit of yo validate that substate regulations has been your verification.		F 1	57			5/28/14
	consult with the resknown, notify the reor an interested far accident involving to injury and has the properties intervention; a significant, mental, or deterioration in heastatus in either life clinical complication significantly (i.e., a existing form of treatment); or a deterioration treatment); or a deterioration the resident from the §483.12(a).	ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in cotential for requiring physician ificant change in the resident's resychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge ne facility as specified in					
	and, if known, the r or interested family	so promptly notify the resident resident's legal representative rember when there is a					
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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

(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245319	B. WING		04/	18/2014
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 157	specified in §483. resident rights und regulations as spethis section.  The facility must rethe address and plegal representative.  This REQUIREMED by: Based on observative review, the facility low blood sugar lether (R3) who is diabeted blood sugars.  Findings include: R3's signed physic indicated that the radicated that the radicate	roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update none number of the resident's e or interested family member.  NT is not met as evidenced ation, interview and document failed to inform the physician of vels timely for 1 of 1 resident c with known history of low iian's order dated 3/5/14 esident was admitted on g to the physician's progress resident's diagnoses included: emia (low blood sugar), sulin used), end-stage renal dialysis, paranoid zure disorder, and major	F 157	1. The physician has been notified blood sugar levels for R3 in a timel manner as per agreed upon param 2. All diabetic residents have poter be affected. Blood sugar physician notification parameters have been reviewed for all deabetic residents. Physicians have been notified in a manner for low blood sugar levels affected residents.  3. Licensed nursing staff have bee educated on the physician notificat policy and procedures related to di blood sugar management.  4. DNS or designess will complete random audits on diabetic resident weekly for four weeks and then more for two months. Results will be communicated to the facility QAPI committee.	eters. htial to timely for all n ion abetic charts	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/20/2014 FORM APPROVED

CENTER	(S FOR MEDICARE	& MEDICAID SERVICES					OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED		
		245319	B. WING	i		04/	18/2014		
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
GOI DEN	LIVINGCENTER - LA	CRESCENT		1	01 SOUTH HILL STREET				
GOLDEN	LIVINGCENTER - LA	CRESCENT		L	LA CRESCENT, MN 55947				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 157	greater than 500. A give glucose 1 tuber alert medical doctor symptoms of hypogo Carbamazepine 30 (insulin) 15 units sur Novolog (insulin) 8 Novolog 3 units SQ had orders for a slice blood sugar level set to be given before a to be given be	tify MD of BS less than 50 or Another order also stated to a gel by mouth for BS 50 and r. May or may not have allycemia; Abilify 45 mg daily, 0 mg twice a day; Lantus abcutaneously (SQ) every day, units SQ at lunch; and a before meals. Resident also ding scale insulin (based on et amount of insulin is given) meals and at bedtime. Signs report indicated that on an another and a blood sugar of 37 er deciliter). The nurse 's at 10:32 p.m. indicated that his p.m. due to Accucheck low absurst for Accucheck of 37 at There was no documentation as notified of the low blood at 5:08 R3's blood sugar was a was given by nurse. There tion that the physician was alwas given by nurse. There tion that the physician was alwas and sugar was 37 mg/dl. mmunication book used for a documented note on 3/8/14 at od sugar was 37. Nurse lucoBurst had been given and breakfast and the BS was 186 antus insulin had been given. She eats. There was no the physician had been	F	157					
		sugar yesterday, 4/15/14, and							

was notified and could not find one.

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245319	B. WING		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	at 8:00 a.m. when a to be called for a lotypically he would extreatment for the lostated he didn't know and sometimes who hospital and the enspecializes in patie orders and at times Physician-D stated resident had a low would treat it and thotified even if the above 50.  A policy titled Diaberevised 2013, indicated as blood gling. Whenever a ghypoglycemia (70 comprovided immediate of diabetes have an monitoring. Medicated parameters in placenty of the provided immediated of diabetic resident guidents.	with physician - D on 4/17/14 asked when he would expect w blood sugar, he stated expect to be notified after the w blood sugar was done. He ow what the current order was en they come back from the docrinologist (a physician who nt/s with diabetes) writes it is kind of confusing. he would expect that if a blood sugar that the nurse nen he would want to be blood sugar had gone up etes Management Guideline, ated that hypoglycemia was ucose less than or equal to 70 llucose test indicates or less) treatment should be ely. Residents with a diagnosis in order for blood glucose all doctor (MD) notification e, glucose gel are used for ts. An acute management of uideline indicated that the notified as directed by blood	F 15			5/28/14
SS=D	A facility must use to develop, review comprehensive pla  The facility must deplan for each reside	CARE PLANS the results of the assessment and revise the resident's	1 213			0/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	[`	(X3) DATE SURVEY COMPLETED	
		245319	B. WING		04/18/2014	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 279	Continued From p medical, nursing, a needs that are ide assessment.  The care plan musto be furnished to highest practicable psychosocial well-§483.25; and any be required under due to the residen §483.10, including under §483.10(b)(  This REQUIREME by: Based on observareview, the facility interventions in resymptoms of seizu prevent injury and comprehensive cat (R3) who was diagreed.  Findings include:  R3's comprehensit the risk factors and	age 4 and mental and psychosocial ntified in the comprehensive  at describe the services that are attain or maintain the resident's exphysical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment 4).  ENT is not met as evidenced ation, interview and record failed to develop seizure gards to detecting signs and ares and safety measure to impaired airway on the re plan for one of one resident gnosed as having seizures.	F 279	1. The comprehensive care plan for has been updated to include seizure interventions in regards to detecting and symptoms of seizures and safet measures to prevent injury and impairway.  2. All comprehensive care plans for residents with diagnosis of seizure has been reviewed and updated as nece to include seizure interventions in regards.	R3 signs y iired ave ssary gards	
	reviewed and did r of seizures, possik anti-seizure medic need to immediate symptoms to the r resident if they hav R3's signed physic	ve care plan dated 4/22/11 was not address signs or symptoms ble adverse side effects of the ine, to alert care givers of the ely report these signs and how to protect the		injury and impaired airway.  3. Licensed nursing staff have been educated on the update comprehens care plans and how to develoop comprehensive care plans for reside with diagnosis of seizures.  4. DNS or designeee will complete random audits on charts for resident diagnosis of seizure for four weeks a then monthly for two months. Result	ents s with and	

PRINTED: 05/20/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	A CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 282 SS=D	note dated 3/5/14 rhistory of hypoglyco Diabetes type 1, er requiring dialysis, p disorder, and majo R3's signed physic indicated that R3 remg orally twice a diseizures. R3 had been seen having seizures a hon 2/28/14 and the documented the produe to profound hy The Director of Nurunable to provide a During a phone cal she did not have a 483.20(k)(3)(ii) SEI PERSONS/PER Comust be provided by accordance with eacare.	g to the physician's progress esident's diagnoses included: emia (low blood sugar), nd-stage renal disease paranoid schizophrenia, seizure r depressive disorder. It is norders dated 3/5/14 esceived carbamazepine 300 ay due to having a history of in the emergency room due to home and R3 was discharged emergency physician incipal diagnosis was seizure poglycemia. It is possible to a specific care plan policy. I on 4/22/13 the DON stated care plan policy. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in each resident's written plan of	F 2		be communicated to the facility QA committee.	PI	5/28/14
	by: Based on interview facility failed to folloresidents (R3) who	NT is not met as evidenced v and document review, the pw the plan of care for 1 of 1 had diabetes and had low had not been reported to the o the plan of care.			The facility followed the updated of care for R3 who had diabetes an low blood sugars by notifying the physician of low blood sugars as perplan of care.      All diabetic residents have potential be affected. Blood sugar physician notification parameters have been	d had er the	

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's cognition was intact. The MDS indicated that R3's cognition was intact. The MDS indicated that R3's cognition was strated. The MDS indicated that R3's expuired 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	CLIVILI	13 I ON MEDICANE	A MEDICAID SERVICES				IVID IVO.	0930-0391
MAKE OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LA CRESCENT  (A) DESCRIPTION STORMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDED BY PLLL RESULLATORY OR LSC IDENTIFYING INFORMATION)  F 282 Continued From page 6  R 3'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 capition was intact. The MDS indicated that R3's 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. The interventions included to observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruit breath odor, coma, nervousness, trembiling, difficulty concentrating, light headedness. Report abnormal results per physician parameters/guideline.  The electronic vital signs report indicated that on 4/15/14, at 1:3:30 p.m. R3 had a blood sugar (BS) of 37 mg/dl (milligrams per deciliter). The nurses note dated 4/12/14, at 1:3:32 p.m. indicated that R3' at a low of a requiring gluco-burst for Accucheck fow and requiring gluco-burst for Accucheck of an and requiring gluco-burst for Accucheck of 37 at 1				` '				
OLDEN LIVINGCENTER - LA CRESCENT   101 SOUTH HILL STREET LA CRESCENT, MIN 55947			245319	B. WING			04/	18/2014
CALL CRESCENT, MN 55947   CALL CRESCENT   CALL CRESCENT, MN 55947   CALL CRESCENT, MN 55947	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALL DEFICIENT   SUMMARY STATEMENT OF DEFICIENCIES   TAG	GOLDEN		CRESCENT		10	01 SOUTH HILL STREET		
FREEIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 signed 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 X28/14, indicated a BIMS (brief interview mental status) score of 15 which indicated that R3's cognition was intact. The MDS indicated that R3's cognition was intact. The MDS indicated that R3 required extensive assist with transfers, dressing and tollet 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 (pisoses. 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. As had a blood sugar (BS) of 37 mg/dl (militigrams per decitier). The nurses note dated 4/15/14, at 10:32 p.m. indicated that R3 that no insulin this p.m. due to Accucheck of 37 at 1	OOLDLIN	LIVINGOLITIER - LA	CONCOCIAT	ļ	L	A CRESCENT, MN 55947		
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'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 (pisodes. 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 myd/l (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 low and requiring gluco-burst for Accucheck of 37 at	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	) BE	COMPLETION
beginning of shift. There was no documentation that the physician was notified of the low blood	F 282	R3's signed physici indicated that the re 3/26/10. According note dated 3/5/14, I history of hypoglyce Diabetes type 1, en requiring dialysis, p disorder, and major The 30 day Prospe Minimum Data Set indicated a BIMS (Escore of 15 which in was intact. The ME extensive assist wit use. R3, interviewed on she had dialysis on Saturdays. R3 stat a.m., eats breakfas back at the facility f R3's care plan date of alteration in blood dependent diabetes blood sugar) episode pisodes. The inte for low blood sugar sweating, change ir irritability, fruity breatermbling, difficulty headedness. Repophysician parameter The electronic vital 4/15/14, at 5:30 p.n of 37 mg/dl (milligranote dated 4/15/14, R3 had no insulin thand requiring glucobeginning of shift.	an's order dated 3/5/14, esident was admitted on to the physician's progress R3's diagnoses included: emia (low blood sugar), d-stage renal disease aranoid schizophrenia, seizure depressive disorder. Cive Payment System (PPS) (MDS) dated 3/28/14, orief interview mental status) andicated that R3's cognition DS indicated that R3 required that ransfers, dressing and toilet 4/15/14, at 4:00 p.m., stated Tuesday, Thursdays and ed that she leaves around 6 to before leaving, and arrives or lunch. If d 4/22/11, identifies a problem diglucose due to insuling mellitus, hyperglycemic (high des, and hypoglycemic riventions included to observe symptoms - flushed face, in usual mental status, lethargy, eath odor, coma, nervousness, concentrating, light of abnormal results per ers/guideline.  Signs report indicated that on in. R3 had a blood sugar (BS) ams per deciliter). The nurses at 10:32 p.m. indicated that inis p.m. due to Accucheck low-burst for Accucheck of 37 at There was no documentation	F 2	282	reviewed for all diabetic residents. Physicians have been notified in a manner for low blood sugar levels affected residents.  3. Licensed nursing staff have been educated on the need to follow the care for all diabetic residents.  4. DNS or designee will complete audits on charts for residents with diagnosis of diabetes for four ween then monthly for two months. Residence communicated to the facility Question.	for all n plan of random as and ults will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245319	B. WING	i		04/	18/2014
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIF 101 SOUTH HILL STREET LA CRESCENT, MN 55947	, CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 282	45. Glucose gel was no documental notified of the low bat 5:15 a.m. R3's bat 5:15 a.m. R3's bat documented that gethat R3 at a small when rechecked. It is sure she eats. The the physician had bat The assistant direct interviewed on 4/16 that R3 had a low band that she had loo physician was notif R3's physician (P)-9:30 a.m., stated the reference to BS of him at that time but doctor. On 4/17/14 would expect to be the low blood sugadidn't know what the sometimes when rehospital and the enkind of confusing. Fafter licensed staff sugar even if the blest of the batter of the	at 5:08 R3's blood sugar was as given by nurse. Again there tion that the physician was blood sugar level. On 3/8/14, blood sugar was 37.0 mg/dl. unication book had a note on ood sugar was 37. Nurse lucoburst had been given and breakfast and the BS was 186 antus given. Please make ere was no documentation that been notified. It or of nursing-B was 6/14, at 9:30 a.m., and stated blood sugar yesterday, 4/15/14, rocked for a fax that the lied and could not find one. D, interviewed on 4/16/14 at that if it was that low (in 37) they would not have called at 8:00 a.m., P-D stated he notified after the treatment for r was done. P-D stated he e current order was, esidents come back from the docrinologist writes orders it is P-D expected to be notified treated the patient's low blood ood sugar had gone up above	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION DING	` '	E SURVEY MPLETED
		245319	B. WING		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 282	acute management indicated that the p directed by blood g	for hypoglycemic events. An of diabetic resident guideline hysician would be notified as lucose.	F 2			
F 283 SS=E	When the facility ar must have a dischar recapitulation of the summary of the resin paragraph (b)(2) the discharge that i authorized persons	AL STATUS  atticipates discharge a resident arge summary that includes a resident's stay; and a final sident's status to include items of this section, at the time of a available for release to and agencies, with the dent or legal representative.	F 2	283		5/28/14
	by: Based on interview failed to complete a recapitulation of sta R53, R67, R2) who facility. Findings include: R61 was admitted thome on 1/24/14. Indicated the dischadiscussed and medicated the care conference documented a disc interdisciplinary dis 1/24/14 indicated R	or and record review, the facility a discharge summary and ay for 4 of 5 residents (R61, were discharged from the on 1/1/14, and discharged Nursing documentation arge instructions were discations sent home with the as transporting the resident.  See note dated 1/16/14, harge plan for R61. The charge summary dated 61 was discharged to home, a recapitulation of stay.		<ol> <li>R61, R53, R67, and R2 have discharged from the facility. No perform the charts.</li> <li>All residents discharged since survey have potential to be affect Discharge summaries and recapt of stays have been completed of dischared residents.</li> <li>Licensed staff have been edut the policy and procedure to complete audits on charts for discharged and the monthly months. Results will be community the facility QAPI committee.</li> </ol>	e the eted. Ditulation in all cated on plete itula of the erandom residents of two	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245319	B. WING _		04	/18/2014	
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP C 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 283	Continued From pa		F 28	33			
		arge orders, discharge tulation of the stay was found rd.					
	11/13/13. Nursing r R53 was discharge had signed a disch	on 11/5/13, and discharged on notes on 11/13/13 indicated ed home with daughter. R53 arge summary, denied pain or k along a medication list.					
	11/13/13 did not ind	ne interdisciplinary discharge summary dated /13/13 did not indicate where the resident was scharged to and did not include a recapitulation stay.					
	discharged on 3/1/wrote orders that R home on current m documentation on discharged to home medication orders. Nursing documents	to the facility on 2/17/14 and 14. On 2/28/14 the physician 167 could be discharged to redications. The nursing 3/1/14, indicated R67 was with the family and that the were faxed to the pharmacy. The resident denied any terms regarding discharge order.					
	3/1/14 indicated R6	y discharge summary dated 67 was admitted on 2/17/14 but ere she was discharged to and tion of stay.					
	discharged on 3/17 stated R2 saw the could discharge to authorizing dischar record. Nursing not discharge instruction	o the facility on 3/5/13 and 7/13. Nursing notes of 3/14/14 physician at the clinic and home. No written order ge was found in the medical tes of 3/17/14 documented ons were reviewed with R2 and tions was reviewed. R2					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245319	B. WING _		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 309 SS=D	medical appointme On 3/11/14 at the codischarge plan was Interdisciplinary Dis 3/17/14 stated R2 will Health and discharge of stay was documed. The director of nurs 4/17/14, at 10:20 at recapitulation of stadischarge orders. The management of the were no writted for R61, R53, R67 and there were no writted for R61, R53 and R483.25 PROVIDE OF HIGHEST WELL BEACH resident must provide the necession maintain the high mental, and psychological mental and plan of care.  This REQUIREMENT by: Based on observative review, the facility for the pisodes of low the second solution.	anding. A list of follow-up ints was provided to R2.  are conference a documented provided to the resident. The scharge Summary dated was admitted from Winona ged to home. No recapitulation ented.  Sing (DON) interviewed on interviewed on interviewed and interviewed as an interviewed on interviewed and interviewed and interviewed and interviewed interv	F 30		ely neters. ntial to	5/28/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/ <sup>-</sup>	18/2014
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LA	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	indicated diagnoses hypoglycemia (low end-stage renal dis seizure disorder. The hospital discha indicated R3 was tr to profound hypogly the facility. The sur hypoglycemia remablood glucose shou higher side. R3's signed physici included treatment follows: For blood significated glycoburst. Reche minutes. For BS grinsulin, if applicable minutes. Notify MD than 500. Another gel by mouth for BS may not have sympthe 30 day Prosped Minimum Data Set a BIMS (brief intervity which indicated that The MDS indicated assistance with trar R3's care plan date of alteration in blood dependent diabetes blood sugar) episodes. The intefor low blood sugar sweating, change ir irritability, fruity breattrembling, difficulty	gress note dated 3/5/14, so that included: history of blood sugar), Diabetes type 1, ease requiring dialysis and arge summary dated 2/28/14, eated following a seizure due ocemia (low blood sugar) at ammary indicated that sined a huge concern and R3's all be allowed to run on the an orders dated 3/5/14 for hypo/hyperglycemia as sugars (BS) less than 60 give ck blood sugar in 15-30 reater than 400 give scheduled at Recheck BS in 15-30 of BS less than 50 or greater order directed glucose 1 tube as 50 and alert MD. May or otoms of hypoglycemia. Cive Payment System (PPS) (MDS) dated 3/28/14 indicated fiew mental status) score of 15 tr R3's cognition was intact. That R3 required extensive ansfers, dressing and toilet use. And 4/22/11, included a problem of glucose due to insuling a mellitus, hyperglycemic (high des, and hypoglycemic reventions included to observe symptoms - flushed face, and usual mental status, lethargy, ath odor, coma, nervousness, concentrating, light out abnormal results per	F	809	reviewed for all diabetic residents. Physicians have been notified in a manner for low blood sugar levels of affected residents.  3. Licensed nursing staff have been educated on the physician notificat policy and procedures related to diablood sugar management.  4. DNS or designee will complete maudits on diabetic resident charts where for four weeks and then monthly for months. Results will be communicated the facility QAPI committee.	for all n ion abetic andom veekly r two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LA	CRESCENT		1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	The electronic vital 4/15/14 at 5:30 p.m mg/dl (milligrams p dated 4/15/14 at 10 no insulin this p.m. requiring Glycoburs beginning of shift. that the physician w sugar. On 4/10/14 awas 45. Glucose g there was no docur was notified. On 3/ sugar was 37.0 mg communication boo indicated Glycoburs ate a small breakfarechecked. There w physician had been The assistant directinterviewed on 4/16/18 had a low blood she could not find awas notified. R3's physician (P)-19:30 a.m., stated the should have been on R3 was interviewed stated she received Thursdays, and Sate ats breakfast before and returns before An interview with the one 4/16/14 at 1:04 protochecked unless hypoglycemia. The the one that monito During an interview physician of low bloods.	signs report indicated that on . R3 had a blood sugar of 37 er deciliter). The nurses note :32 p.m. indicated that R3 had due to Accucheck low and st for Accucheck of 37 at There was no documentation was notified of the low blood at 5:08 p.m. R3's blood sugar el was administered; however, mentation that the physician 8/14, at 5:15 a.m. R3's blood /dl according to the dialysis ok. Nurse's documentation at had been given and that R3 st and the BS was 186 when was no documentation that the notified. Stor of nursing (ADON)-B, 1/14 at 9:30 a.m. stated that sugar yesterday, 4/15/14, but any evidence the physician contacted regarding low BS. I on 4/15/14 at 4:00 p.m. and I dialysis on Tuesday, turdays. R3 stated that she re leaving around 6:00 a.m.	F3	809			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, 101 SOUTH HILL: LA CRESCENT,		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD FERENCED TO THE APPROPOLIC DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315 SS=E	sugar was below 5 and recheck and the below 50 or above change today, she physician to let him level.  On 4/17/14 at 7:00 Pharmacist (RP)-Could be related to example the antips blood sugar levels. Physician (P)-D, in a.m., stated he would wan blood sugar had go A policy titled Diaberevised 2013, indicated as blood glung. Whenever a ghypoglycemia treat immediately. Residiabetes have an omonitoring. MD no glucose gel is used 483.25(d) NO CAT RESTORE BLADD.  Based on the residuassessment, the faresident who enterindwelling catheter resident's clinical coatheterization was who is incontinent of treatment and service.	ten changed that day. If blood they are to give the glycogen then call the physician if still 400. LPN-B stated before the would have called the know of the low blood sugar a.m. the Registered stated that hypoglycemia R3's other medications, for sychotic Abilify could cause low terviewed on 4/17/14 at 8:00 buld expect that if a resident gar the nurse would treat it and to be notified even if the one up above 50. The Management Guideline, ated that hypoglycemia was sucose less than or equal to 70 glucose test indicates ment should be provided dents with a diagnosis of order for blood glucose testification parameters in place, if for hypoglycemic events. HETER, PREVENT UTI,	F3				5/28/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/1	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	by: Based on observate review the facility fare urinary tract infection (R59, R71, R11, R4 utilizing prophylaction of the state of the	NT is not met as evidenced ion, interview and document iled to assess the risk for ons (UTIs) for 4 of 4 residents (UTIs) for 4 of 4 residents (UTIs) identified by the facility as antibiotics to prevent UTIs.  On 4/14/14 at 9:30 a.m. R59 and reading the newspaper. On 4/15/14 at 9:27 a.m., R59 appendent with most of her interview on 4/18/14 at 9:45 ant (NA)-A stated R59 was at staff would help with a requested the help.  Coian orders of 3/14/14 included 50 mg by mouth at bedtime TI. The physician (75/14 indicated a problem list is, history of depression, rinary tract infections and	F 3	15	1. The facility assessed the risk for urinary tract infections (UTI's) for residents (R59, R11, R45) identified the facility as utilizing prophylactic antibiorics to prevent UTI's. R71 had discharged from the facility.  2. All residents who have a history diagnosis of chronic UTI's have portobe affected. These residents have assessed for risk for UTI's.  3. Licensed nursing staff and attemphysicians have been educated on utilization of a UTI risk assessment 4. DNS or designee will complete raudits on charts for who have a his chronic UTI's weekly for four weeks then monthly for two months. Resulted to the facility QA committee.	d by as and cential ve been ding the andom tory of s and lts will	
	monitor for recurring physician document R59 had a recurren	g symptoms. Review of the tation of 3/19/14 indicated turinary tract infection, but of symptoms of an infection.					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION  IG		TE SURVEY MPLETED
		245319	B. WING _		04	/18/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 315	The bladder asses indicated R59 was was no document physical abnormal post void residuals evaluate R59's ris infections or that sprophylactically. Nassessment or evadmission Minimus 2/5/14 indicated R of mental status) srequired supervisi hygiene, was contutt in the past 30 assessment (CAAT The care plan prin required personal toileting assistance plan indicated a pelimination of bow UTIs with antibioti directed to monito UTI and to provide to use briefs/pads  The director of nu 4/18/14 at 9:30 a.urinary tract infect 9:40 a.m. DON staurinary tract infect R 71 was observe independently utili therapy room. At stated R71 was mindicated	ssment form dated 2/3/14 continent of bladder. There ation of assessment for any ities, recent urinalysis or any s. The assessment form did not k to develop urinary tract the was on Keflex daily No further urinary/bladder aluation was found. The m Data Set (MDS) dated 59 had a BIMS (Brief interview score of 14 or cognitively intact, on assistance for toileting and inent of urine, had not had a days. No care area	F 31	5		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245319	B. WING		04	/18/2014
	PROVIDER OR SUPPLIER	CRESCENT	•	STREET ADDRESS, CITY, STATE, ZIP COI 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	as needed. NA-C spersonal hygiene of for help with transfer R71 was admitted listed on the physic peripheral neuropa constipation, chron recurrent urinary transfer A urology note date history of recurrent antibiotics at bed times at bed times and indicated reprophylactic Trimethoprim 50 m recurrent urinary transfer to ileting and hygwas not found.  During an interview director of nursing for a UTI following stated a urinary transfer to interviewed at 9:44 R11 required total and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29/12 indictionic urinary transfer and required exten R11 was admitted dated 11/29	stated staff set her up for ares and that R71 would ask ers.  on 4/1/14 and had diagnosis ian notes of 4/2/14 as thy, diabetes, recurrent ic kidney disease and act infections.  ad 2/21/13 stated R71 had a UTI and was on prophylactic me. Urology note dated ecurrent UTI and use of hoprim (antibiotic) 50 mg at a orders dated 4/1/14 include g by mouth at bedtime for	F 3	15		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		101	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH HILL STREET CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	indicated that since prophylactic antibiotic would be notes indicated rec Physician orders simg by mouth at beinfection.  A bladder assessm R11 was incontiner some daily control, antidepressant, and assessment identifit The form did not in any physical abnorror any post void redid not evaluate R1 infections or that sh prophylactically. The quarterly MDS had a BIMS score or required extensive personal hygiene, whad a UTI in the path a UTI in the path a UTI in the path and change every a care plan printed a hygiene and toiletin and change every a care plan printed a hygiene and toiletin and report signs an provide assistance	11/29/12 documentation the discontinuation of the tic R11 had experienced three cian felt a prophylactic warranted. 11/29/12 urology urrent E.Coli UTI. gned 4/16/14 noted Keflex 250 d time for urinary tract  ent dated 8/23/13 indicated at of bladder but may have received diuretics, was on an d had mild dementia. The ed stress urinary incontinence. dicate R 11 was assessed for malities, and recent urinalysis, siduals. The assessment form 1's risk to develop urinary tract he was on Keflex he care area assessment urinary incontinence noted der due to nerve damage dated 2/21/14 indicated R11 of 15 or cognitively intact, assistance with toileting and vas always incontinent and st 30 days. ed 3/13/14 identified a problem ing deficit that directed staff ssistance of one for personal g assistance of one to check c hours and as needed. The f13/14 identified a problem of ation. Frequent incontinence of entions that directed monitor d symptoms of UTI and	F3	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING _		04	/18/2014	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LA CRESCENT				STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL BY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	LD BE COMPLÉTION	
F 315	that a urinary tract not been completed had seen a urologist primary physician be information was proposed information was admitted note of 3/5/14 listed disease and incont of 5/2/13 noted R44 overactive bladder) for UTI prophylaxis 3/5/14 included Trip bedtime  The bladder assess incontinence with left frequently. The aspossible physical a or post void residual evaluate R45's risk infections or that stip prophylactically. Tidated 1/27/13 identifications was proposed in the stip of the st	st had a UTI on June 2013 and infection risk assessment had d. The DON was unsure if R11 st as recommended by the but would look. No further	F 31	5			
	BIMS score of 6 or frequent incontiner	dated 2/14/14 indicated a severe cognitive impairment, ice, assist of one with toilet use ine, and no UTIs in the past 30					

		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COI	(X3) DATE SURVEY COMPLETED	
	245319	B. WING _		04	/18/2014	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LA CRESCENT			STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947			
PREFIX (EACH DEFICIENCY MUST	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLÉTION		
that she was not able to assessment.  F 329 SS=E UNNECESSARY DRUG Each resident's drug reg unnecessary drugs. An drug when used in exces duplicate therapy); or for	al functioning deficit personal hygiene ssistance with perineal shift. The care plan dalteration in elimination equent functional ed monitor and report UTI.  /18/14 at 9:30 a.m. the ITI was in May 2013 and find a UTI risk  EN IS FREE FROM S  simen must be free from unnecessary drug is any ssive dose (including excessive duration; or oring; or without adequate in the presence of which indicate the dose scontinued; or any sons above.  Sive assessment of a trensure that residents expected that residents expected as specific condition mented in the clinical no use antipsychotic drug sereat a specific condition mented in the clinical no use antipsychotic dose reductions, and unless clinically	F 3:			5/28/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245319	B. WING		04/18/2014	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LA CRESCENT			STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947			10/2014
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	O BE COMPLÉTION	
F 329	Continued From page 20		F 329	529		
	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			1. The facility identified, assessed a monitored the clinical indications for of psychoactive and PRN pain medications for residents (R56, R19). All residents who have prescribed psychoactive and/or PRN pain medications have potential to be aff. The facility identified, assessed and monitored the clinical indications for of psychoactive and PRN pain medications for all residents person psychoactive and/or pain medications. Licensed nursing staff have been educated on the need to identify, as and monitor the clinical indications of psychoactive and PRN pain medications. 4. DNS or designee will complete reaudits on charts who have been prescribed psychactive or PRn pain medications weekly for four weeks then monthly for two months. Result be communicated to the facility QAI committee.	r use 9, R8). d fected. If r use libed ns. If ssess for use andom land lts will	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	records the following dates of 3/17/14 the received a total of 35 doses of PRN of doses of PRN Tyle 4/1/14 through 4/16 doses of PRN loration oxycodone-acetam Tylenol. R56's progethrough 4/16/14 ide was not clearly iderit was given.  During interview or Assistant director of physician orders la oxycodone-acetam or two tablets.  During interview or for incomplete the consultant parameters for PR of when to give one 3:52 p.m., director expect consultant parameters and no concerns.  Document review of substance prescription: 13) Pl delineate the conditional delineate the conditional delineate for experience pain (pain severe pain severe pain (pain severe	56's medication administration of had been noted: from the rough 3/31/14 R56 had had 18 doses of PRN lorazepam, exycodone-acetaminophen, 3 nol and from the dates of 5/14 R56 had received 14 zepam, 24 doses of PRN gress notes dated 3/17/14 entified the use of the Ativan intified as to parameters to why in 4/17/14, at 2:25 p.m., of nursing verified R56's cked parameters for PRN gress notes dated 3/17/14 entified as to parameters to why in 4/17/14, at 2:25 p.m., of nursing verified R56's cked parameters for PRN gress notes dated R56's physician orders lacked R5	F 32	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED			
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		101	REET ADDRESS, CITY, STATE, ZIP CODE  1 SOUTH HILL STREET  A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 22	F3	29			
	identified mood syneffective or not. R19's physician ord that R19 was admit including, but not lir dementia with beha state, generalized prodisease state III (mathematical mathematical ma	nal Data Set (MDS) dated hat R19's BIMS (brief atus) was 9 out of 15 indicating hely impaired. If R19's physician orders dated hat R19 received Celexa ay for anxiety state. If R19's physician orders dated hat R19 received Celexa ay for anxiety state. If R19's physician orders dated hat R19 received Celexa hat R19 was receiving an dication and that R19 had the gns and symptoms of mood I indicated that R19 would talk and happy memories during erventions included: If Volved in activities related to a in contact with family and dications that help with hage any side effects, and to cous feelings when feeling helm dated 8/2/13 indicated tential for drug related ciated with the use of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245319	B. WING _		04/	18/2014		
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947		10/2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 329	Monthly pharmacy Provide non-pharm with family and frie bingo and music priete tup. To decrea depression. During observation 4/16/14 at 7:29 a.m walking out of the bassistant. R19 star and moving around 4/16/14 at 8:13 a.m room and was observation with her tablemates. An interview with n 4/17/14 at 1:08 p.m displayed her anxiothat she would get and not wanting to were no comments associated with it. During an interview p.m. when asked a moods, LPN-A stat the hallucinations when was unclear with the use of the antic During an interview (DON) on 4/17/14 at that R19 was recent delusional disorder DON stated that R room. A review of the beh February, April and	changes to physician. review of medication regimen. raceutical interventions of visits ands, attending activities like rograms, resting in recliner with se target behaviors, anxiety or and interview with R19 on an resident was observed bathroom with a nursing ted it's better once she gets up d. During observation on an R19 was out in the dining erved laughing and conversing and the administrator. ursing assistant (NA)-D on and, when asked how R19 busness or mood, NA-D stated very upset about her whirlpool get her hair ruined. There about mood or symptoms  with LPN-A on 4/17/14 at 2:15 bout R19's behaviors or ed that she didn't know what were, and LPN-A stated that hat R19's symptoms were for depressant. with the Director of Nursing at 2:30 p.m., the DON stated only hospitalized for a and a control of the	F 32	9				
		noia/delusion was the behavior						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		1	OT SOUTH HILL STREET  A CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	Documentation indicator. The quarterly interedated 3/12/14 underedated anxious at quantitative behavior. No policy on targets after being requested. R8 received an antithere were no clear specific to this resist the antidepressant R8's physician ordered R8 was admitted or including: senile dedepressive disorder. The quarter MDS dedepressive was 9 or cognition was moded. R8 was receiving Z	cated no behaviors observed February 2014 for on with no individualized mood disciplinary resident review or behavioral symptoms on the use of an antidepressant. Itimes, with no individual or or documented. The ded behaviors were provided and on 4/18/14.  Indepressant medication yet of mood symptoms/signs dent identified to determine if was affective or not. For stated 4/1/14 indicated that in 11/26/05 with diagnoses ementia, hemiplegia, or, and generalized anxiety atted 3/20/14 indicated R8's out of 15 which indicated that oloft 50 mg every day for	F3	329			
	a problem of R8 fee lonely, angry. No identified. During an interview	e care plan dated 5/21/11 had eling sad and restless, irritable, mood behaviors were  with R8 on 4/16/14 at 7:05 waiting for breakfast in room					
	while watching TV pretty good and she During observation R8 was in the dining behaviors of yelling	R8 stated her appetite was e didn't really like watching TV on 4/16/14 at 8:09 a.m. while g room at a table by self, no out were observed. avior monthly flow sheet for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245319	B. WING _		04	1/18/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL AND INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 428 SS=D	R8's behavior code screaming/yelling. changes were ider During an interview when asked how FNA-D stated that Fout, and is irritable symptoms associa During an interview about how R8 disp stated that she had out and did not kno behaviors. During an interview (DON) on 4/17/14 that a long time aginappropriate behawith yelling out. The mood. 483.60(c) DRUG FIRREGULAR, ACT The drug regimen reviewed at least opharmacist. The pharmacist methe attending phys	and April of 2014 indicated that a was angry and continuous No individualized mood ntified.  In with nursing assistant (NA)-D as displays mood changes, as is attention-seeking, yells but had no comments about atted with depression.  In with (LPN)-A, when asked blays mood behaviors LPN-A and never seen R8 scream or yell ow any identified mood  In with the Director of Nursing at 2:30 p.m., the DON stated to R8 had sexually aviors and has some issues here was no monitoring of	F 32			5/28/14	
	by:	NT is not met as evidenced w and document review, the		The facility pharmacy const	ultant		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	18/2014
NAME OF	PROVIDER OR SUPPLIER	3		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - L	A CRESCENT			01 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	facility failed to en identified lack of pmedications for 1 to identify lack of (R19, R8) for psycfor unnecessary nor unnecess	sure the pharmacy consultant parameters for as needed pain of 5 residents (R56) and failed monitoring 2 of 5 residents chotropic medications reviewed	F	128	identified lack of parameters for as needed pain medications for reside (R56) and identified lack of monitor residents (R19, R8) for psychotropimedications. The consultant communicated findings and recommendations to the facility DN 2. All residents have ptential to be affected. The facility has ensured the drug regimen of each resident was reviewed at least once a month by licensed pharmacist. The pharmac reported any irregularities to the att physician, and the director of nursing these reports were acted upon.  3. The facility pharmacy consultant DNs were educated on the expectate that the drug regimen of each resident the drug regimen of ea	ent ring for ic IS. Is. nat the a ist ending ng, and ation lent nonth rmacist	
	revealed an order anti-anxiety medic eight hours as new oxycodone-acetar 5-325 mg one to the for pain, do not exindication on physical give one tablet or medication) 650 m PRN for pain.  During review of Frecords the follow dates of 3/17/14 to	sician orders dated 3/38/14, for lorazepam (Ativan) (an cation) 0.5 mg (milligrams) every eded (PRN) for anxiety, minophen (a pain medication) wo tabs every four hours PRN ceed 12 tablets per day (no ician orders identified when to two tablets) and Tylenol (a paining once a day at HS (bedtime)  R56's medication administration ing had been noted: from the brough 3/31/14 R56 had had 18 doses of PRN lorazepam,			nursing, and these reports must be upon.  4. DNS or designee will complete r audits on charts monthly for three r to confirm all residents have been reviewed by the pharmacy consult least once a month and that irregul were communicated appropriately DNS and attending physicians. Reswill be communicated to the facility committee.	andom months ant at arities to the sults	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	A CRESCENT		1	STREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	35 doses of PRN or doses of PRN Tyler 4/1/14 through 4/16 doses of PRN loraze oxycodone-acetam Tylenol. R56's programment frough 4/16/14 idea was not clearly idea it was given.  During interview on Assistant director or physician orders las oxycodone-acetam or two tablets.  During interview on for form of nursing verified in parameters for PRI of when to give one 3:52 p.m., director expect consultant programments and no concerns.  Document review of substance prescription: 13) Procedures A. Eleprescription: 13) Procedures delineate the conditional for expect pain (pain severe pain for expect and pain severe pain (pain severe pain (pain severe pain (pain severe pain for expect and pain severe pain (pain severe pain (pain severe pain (pain severe pain parameters and pain severe pain (pain severe pain (pain severe pain (pain severe pain parameters and pain severe pain (pain severe pain (pain severe pain (pain severe pain parameters and pain severe pain (pain severe pain pain severe pain pain severe pain (pain severe pain pain severe pain severe pain pain severe pain severe pain severe pain severe pain severe pain pain severe pain sever	exycodone-acetaminophen, 3 mol and from the dates of 5/14 R56 had received 14 gepam, 24 doses of PRN inophen, one dose of PRN inophen, one dose of PRN iress notes dated 3/17/14 gentified the use of the Ativan intified as to parameters to why in 4/17/14, at 2:25 p.m., of nursing verified R56's coked parameters for PRN inophen of when to give one in 4/17/14, at 2:59 p.m., Director R56's physician orders lacked in Noxycodone-acetaminophen is or two tablets. On 4/17/14, at of nursing state she would other macist to have identified in-pharmacological measure of the facility policy controlled tions dated revised 11/11, read genents of controlled substance in the facility policy controlled tions dated revised 11/11, read genents of controlled substance in the facility policy controlled tions dated revised 11/11, read genents of controlled substance in the facility policy controlled tions dated revised 11/11, read genents of controlled substance in the facility policy controlled substance in the facility policy controlled substance in the facility policy controlled genents of controlled substance in the facility policy controlled substance in the facility policy controlled in the facil		128			
		exa an antidepressant without nptoms to monitor if it was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/1	8/2014
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
F 428	that R19 was admi including, but not li dementia with beha state, generalized places estate III (magnetic The quarterly Minima) 12/14 indicated the interview mental strong to the review of 4/16/14 it was indicated a problem antidepressant me potential to show sconcerns. The goa about positive topic conversations. Interests, help keep friends, to give mendepression and matake the time to dissad. A second protect that there was a pocomplications assorpsychotropic medicantidepressant me included to assess effects and report to signs/symptoms of self to room, making document. Report Monthly pharmacy Provide non-pharm	ders dated 4/16/14 indicated tted on 7/11/13 with diagnoses mited to: delusional disorder, avioral disturbance, anxiety pain and chronic kidney moderate).  Inal Data Set (MDS) dated mat R19's BIMS (brief atus) was 9 out of 15 indicating tely impaired.  In R19's physician orders dated mat R19's physician orders dated that R19 received Celexa day for anxiety state.  In that R19 was receiving an dication and that R19 had the igns and symptoms of mood all indicated that R19 would talk as and happy memories during erventions included:  Involved in activities related to be in contact with family and dications that help with anage any side effects, and to cous feelings when feeling blem dated 8/2/13 indicated brential for drug related to coited with the use of	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014		
	PROVIDER OR SUPPLIER	CRESCENT		101	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH HILL STREET CRESCENT, MN 55947	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 428	bingo and music pr feet up. To decreas depression. During observation 4/16/14 at 7:29 a.m walking out of the bassistant. R19 stat and moving around 4/16/14 at 8:13 a.m room and was obse with her tablemates An interview with ne 4/17/14 at 1:08 p.m displayed her anxio that she would get and not wanting to were no comments associated with it. During an interview p.m. when asked a moods, LPN-A stat the hallucinations w she was unclear wh the use of the antid During an interview (DON) on 4/17/14 at that R19 was recer delusional disorder DON stated that R2 room. A review of the beh February, April and depressed withdraw hallucinations/para code. Mood chang Documentation ind except one time in	ograms, resting in recliner with se target behaviors, anxiety or and interview with R19 on a resident was observed bathroom with a nursing ed it's better once she gets up and the administrator. During observation on and the administrator. During assistant (NA)-D on any when asked how R19 are used about her whirlpool get her hair ruined. There about mood or symptoms with LPN-A on 4/17/14 at 2:15 bout R19's behaviors or ed that she didn't know what were, and LPN-A stated that hat R19's symptoms were for epressant.  With the Director of Nursing at 2:30 p.m., the DON stated that hat R19's depression, the light would not come out of her avior monthly flow sheet for March of 2014, indicated that we and hoia/delusion was the behavior es were not being monitored. Cated no behaviors observed	F 4	28					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014	
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LA	CRESCENT		10	REET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HILL STREET A CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 428	dated 3/12/14 under indicated none, with Marked anxious at quantitative behavior. No policy on targete after being requested. R8 received an antithere were no clear specific to this reside the antidepressant R8's physician order. R8 was admitted or including: senile dedepressive disorder disorder. The quarter MDS depressive disorder disorder. The physician's order R8 was receiving Z depressive disorder depressive disorder. The comprehensive a problem of R8 feet lonely, angry. No identified. During an interview a.m., resident was while watching TV pretty good and she During observation R8 was in the dining behaviors of yelling A review of the beh February, March, at R8's behavior code	isciplinary resident review r behavioral symptoms in the use of an antidepressant. Itimes, with no individual or or documented. It behaviors were provided and on 4/18/14.  Idepressant medication yet mood symptoms/signs ident identified to determine if was affective or not. It is dated 4/1/14 indicated that in 11/26/05 with diagnoses in the minimum of the interest in the interest interest in the interest interest in the interest interest interest in the interest interest interest interest in the interest interest interest in the interest inte	F 4	28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP COL 101 SOUTH HILL STREET LA CRESCENT, MN 55947	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
F 428	when asked how R NA-D stated that Rout, and is irritable symptoms associat During an interview about how R8 displ stated that she had out and did not knobehaviors.  During an interview (DON) on 4/17/14 at that a long time againappropriate behavior with yelling out. Th mood.  483.60(b), (d), (e) E	with nursing assistant (NA)-D 8 displays mood changes, 8 is attention-seeking, yells but had no comments about ted with depression.  with (LPN)-A, when asked ays mood behaviors LPN-A never seen R8 scream or yell w any identified mood  with the Director of Nursing at 2:30 p.m., the DON stated of R8 had sexually viors and has some issues ere was no monitoring of	F 4				5/28/14
SS=E	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in orde controlled drugs is reconciled.  Drugs and biological abeled in accordan professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted bles, and include the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	· ·	(X3) DATE SURVEY COMPLETED		
		245319	B. WING		04/18/2014		
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  A CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
F 431	The facility must proper manently affixe controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districts.	it only authorized personnel to keys.  rovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to the facility uses single unit ibution systems in which the minimal and a missing dose can	F 431				
	by: Based on observate failed to ensure that kit were stored prorooms and failed to was not available f (R12).  During the tour of the was observed that contained narcotic secure lock only as separately locked, compartments, exceedingle unit medicate which the quantity missing dose can be controlled medicated.  On 4/17/14 at 3:12	NT is not met as evidenced ation and interview, the facility at narcotics in the emergency perly in 1 of 1 medication or use for 1 of 1 residents  the medication storage room it the emergency kit which is were stored under a single and are to be stored in permanently affixed cept when the facility uses ion distribution systems in stored is minimal and a per readily detected; and ions are reconciled accurately.		1. The facility ensured that narcotics the emergency kit were stored proper the medication room and ensured expression was not available for use resident (R12).  2. All residents have potential to be affected by these practices. The narcon the emergency kit have been properstored. Expired medication for all residents have been removed.  3. Licensed nursing have been education the need to properly store the narcon the need to properly store the narcon the medications.  4. DNS or designee will complete randaudits on the medication room month three months to confirm all narcotics a sotred properly. DNS or designess will complete random audits on medication.	ely in bired for otics erly ated eotics dom ly for are II		
	emergency kit had	a tag on it but was not locked the lock on the door to the		carts weekly for four weeks and then monthly for two months to confirm exp			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LA	CRESCENT		1	STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	storage room. This nurse (RN)-B.  The Director of Nurp.m. confirmed this following was in the Injection 5 mg/ml (\text{Nydrocodone/Apap} Lorazepam 0.5 mg mg/ml 1 30 ml vial, tablets.  A policy titled Contr dated 05/12 indicate medications and other abuse or diversion affixed, double-lock from all other medications and other medications are diversionally of the properties of the	sing (DON) on 4/17/14 at 3:33 and also confirmed that the emergency kit: Diazepam /alium) 1- 10 ml vial. 5/325 mg (Lortab)12 tablets. (Ativan), Morphine Sulfate 20 and oxycodone 5 mg, 12  olled Substance Storage ed that schedule II-V her medications subject to are stored in a permanently ed compartment separate cations or per state regulation.  p.m. during the review of the RN)B it was noted that a bottle ets had the seal broken and 12. This was undated as to 3 and it had been filled on ealth Direct Pharmacy. The 4/2013. RN-B stated that she ad brought them in upon confirmed that these were have the date on it when it  or's dated 3/19/14 indicated that on 11/11/13 with diagnoses mentia, chronic ischemic heart ate, depressive disorder, and paralysis agitans. The Data Set (MDS) dated 2/18/14 (Brief Interview for Mental et of 9 out of 15 indicating	F 4	131	and/or unlabeled medications have removed. Results will be communic the facility QAPI committee.		

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		245319	B. WING		,	4/18/2014
	IDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP COD  101 SOUTH HILL STREET  LA CRESCENT, MN 55947	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
mo ord rec (SL at 5 Wh p.m poli Pro 05/ incl cor rem disp sch dou 5 SS=E SP The Infe safe to h of c (1) in the Pro (1) in the (2) show (3) acti	ders dated 11/12/2 seive nitroglyceria. Das necessary in the servention of the control of the co	d cognition. A signed standing (13 indicated that R12 could in 1/150 (0.4 mg) sublingual for chest pain. May repeat x 2 is.  If the DON on 4/17/14 at 3:33 of the medication room and a ne DON provided the CQI Medication Storage dated is had a check off list that ed, deteriorated or cations are properly identified, medication cart, stored and y. It also indicated that tions are maintained in age with restricted access. I CONTROL, PREVENT  Itablish and maintain an cogram designed to provide a comfortable environment and development and transmission ction.  Il Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections.	F 4			5/28/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/1	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is incorposessional practice. (c) Linens Personnel must han transport linens so infection.  This REQUIREMENT by: Based on observative review the facility faprocedures during to failed to implement possible spread of imponitoring observative who had blood sugar Findings Include:  R43 was observed change to the foot of licensed practical nexam gloves to remain the area with wound gloves and went to	esident needs isolation to of infection, the facility must assert prohibit employees with a assert infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted ite.  Indie, store, process and as to prevent the spread of as to prevent the spread of ion, interview, and record alled to maintain sanitary wound dressing change for 1 or reviewed for wound care; procedures to prevent the infection during blood glucose tions for 1 of 2 resident (R18)	F	141	1. The facility maintained sanitary procedures during wound dressing change for resident (R43). Resident has been discharges. The facility implemented procedures to prevent possible spread of infection during the glucometer cleaning process for residents who have orders for dressing changes and blood sugar monitoring have potential to be affect the facility maintained sanitary procedures during would dressing changes for residents who have orderessing changes. The facility implemented procedures to prevent possible spread of infection during the glucometer cleaning process for residents who have orderessing changes for residents who have orderessing changes. The facility implemented procedures to prevent possible spread of infection during the glucometer cleaning process for residents.	the blood sident cted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/1	18/2014
	PROVIDER OR SUPPLIE			1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	R43's over the be gloves and applied a sterile to right hand. She the sitting on the over her right hand, cut her pocket using roll of tube gauze tube gauze to R4: gloves, LPN-A plat the box and state to the storage clost. The director of nut 4/16/14 at 10:30 at gauze should not storage closet. Dowere to be kept in dressing was to underessing should be	d table. LPN-A put on clean d a new dressing. LPN-A elpha pad to the area with her hen took tube gauze that was bed table out of the box with the gauze with a scissors from her left hand and returned the to the table. She applied the 3's foot. After removing her aced the roll of tube gauze into d she was going to take it back set.  Irsing (DON) was interviewed on a.m. DON stated the tubular have been opened and in the ON stated only sealed dressing a the storage closet. If a sed for the resident, that he kept with the other treatments DON stated the dressings were	F	141	who have orders for blood sugar monitoring.  3. Licensed nursing staff have bee educated on the proper sanitary procedures for wound dressing charand blood glucometer cleaning.  4. DNS or designee will complete robservations on nurses completing dressing changes weekly for four vand then monthyly for two months. or desingee will complete random observations of nurses completing glucometer cleaning weekly for four weeks and then monthly for two months and the monthly for two months.	anges andom wound weeks DNS blood r onths.	
	a blood glucose le was observed to o which RN-A had g discarded the use out of the glucom end of strip stickir sharps container RN-A had then ca hallway to the me glucometer on the had not been cleahands and proceemedications. Surv	awn on 4/16/14, at 7:25 a.m., for evel. Registered nurse (RN)-A check R18's blood sugar during gloves on and had removed and ed blood glucose strip sticking eter (which had visible blood on an out of the glucometer) into a hanging on R18's room door. It is a room door, arried the glucometer out into the dication cart, laid the elemedication cart (glucometer aned), removed gloves, washed eded to start setting up to pass veyor intervened and verified at A the glucometer had not been					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		1	OTREET ADDRESS, CITY, STATE, ZIP CODE O1 SOUTH HILL STREET LA CRESCENT, MN 55947	1 0-11	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	put it away." RN-A each medication cal between residents a alcohol pad to clear proceeded to pick us gloves on and clear alcohol pad. RN-A gloves on when cle used an alcohol pad. However, the gluco with a product recordiseases.  During interview on of nursing had state be followed and usefull minute as policy glucometer and glocleaning the glucon  Document review on DECONTAMINATION "PURPOSE: To improcess for decontation Dispatch wipes will disinfectant. This is tuberculocidal; effectionad spectrum of I based and meets reequipment for Clost Dispatch is not avain may be substituted use on each reside manufacturer's recordilowed. Procedure glucometer along will glucometer alon	stated, I won't clean it until I stated only one glucometer for it, the glucometer is shared and had stated uses an in the glucometer. RN-A had up the glucometer without in the glucometer without in the glucometer with an verified at the time had no aning the glucometer and had do to clean the glucometer. I meter had not been sanatized immended to kill blood bourne in the glucometer. I will blood bourne in the glucometer and had do to clean the glucometer. I will blood bourne in the glucometer in the glucometer. I facility policy GLUCOMETER in the glucometer in th	F 4	141			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245319	B. WING		04/1	18/2014
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 F 465 SS=E	testing, the nurse, of dispatch wipe to wing glucometer. III. The placed on another premoved and hand glucometer will be por other clean store 483.70(h) SAFE/FUNCTIONAE ENVIRON The facility must pr	ter performing the glucometer wearing gloves, will use a pe all external parts of the clean glucometer will be paper towel. IV. Gloves will be hygiene performed. V. The placed in the medication cartage area until needed."  AL/SANITARY/COMFORTABL  ovide a safe, functional, ortable environment for	F 4			5/28/14
	by: Based on observation failed to ensure fau build up on bathroot sanitized able surfat whose faucets were build-up. Findings include: An observation on a that bathroom fauce 209, had calcifications spigot and knobs. 6:10 p.m. with Main were lime covered to be replaced. Mathard water and only During an environment of the property o	NT is not met as evidenced tion and interview, the facility cets were clear of calcification in faucets to promote a ce for 3 of 5 bathrooms in coated with calcification.  4/14/14 at 6:10 p.m. indicated ets in rooms 104, 205, and for of lime built up around the An interview on 4/14/14 at the nance-A verified the faucets and felt that they would need intenance-A stated they have the warm water is softened.  The nental tour with (maintenance) to the sink in the properties of the sink in the sink		1. The three faucets in three identic bathrooms have been cleaned or reas necessary. 2. All residents have potential to be affected by this practice. All faucets either cleaned or replaced as necestive to calcification. 3. The Maintenance Director has be educated on the need to monitor an address the calcification of resident faucets. 4. The ED or designee will complet random audits of resident rooms farmonthly for three months. Results we communicated to the QAPI commits.	eplaced s were ssary een nd t rooms ee nucets will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	18/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI  101 SOUTH HILL STREET  LA CRESCENT, MN 55947	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 465	confirmed that room faucet with lime conthe sink onto the win room 205 the ba	n replaced. Maintenance-D m 104 in the bathroom had the vered and the screws holding valls were uncovered. And that throom sink faucet at the end nick lime built up and that the	F 4	H65			

F5319023

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	17/2014
	PROVIDER OR SUPPLIER	A CRESCENT		101	REET ADDRESS, CITY, STATE, ZIP CODE I SOUTH HILL STREET CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	тѕ	K	000			
	ALLEGATION OF DEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION RECEIPT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HACCORDANCE WAS A Life Safety Code Minnesota Department of Participation in Substantial complete for participation in Subpart 483.70(a), 2000 edition of Nat Association (NFPA Code (LSC), Chapille PLEASE RETURN	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.  Survey was conducted by the nent of Public Safety - State on. At the time of this survey, er - La Crescent was found not bliance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection ) Standard 101, Life Safety ter 19 Existing Health Care.  THE PLAN OF PR THE FIRE SAFETY  ISPECTIONS Division Suite 145			EPOC		

**Electronically Signed** 

TITLE

05/16/2014

(X6) DATE

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

program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245319	B. WING			04/	17/2014
	PROVIDER OR SUPPLIER	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa		ΚŒ	000			
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO						
	A description of value to correct the deficite	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
	The name and/o responsible for correprevent a reoccurrent.	r title of the person rection and monitoring to ence of the deficiency.					
	1-story building with	center - La Crescent, is a n no basement. The facility 1968 and was determined to construction.					
	alarm system with the and spaces open to	sprinklered and has a fire full corridor smoke detection to the corridor that is monitored epartment notification.			*		
		apacity of 45 beds and had a at the time of the survey.					
K 067 SS=F	NOT MET as evide	: 42 CFR Subpart 483.70(a) is enced by: FETY CODE STANDARD	K	)67			<del>5/28/14</del>
55-1	with the provisions	, and air conditioning comply of section 9.2 and are installed the manufacturer's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 4	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245319	B. WING _		04/17/2014	
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP COL 101 SOUTH HILL STREET LA CRESCENT, MN 55947	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 067		ige 2 9.5.2.1, 9.2, NFPA 90A,	K 06	67		
<	Based on observa facility's general ve system (HVAC) is r the LSC, Section 1	s not met as evidenced by: tions and staff interviews, the ntilating and air conditioning not installed in accordance with 9.5.2.1 and NFPA 90A, Section liant HVAC system could affect		Waiver request for this def been submitted.	ficiency has	5
	on 04/17/2014, obstacility Maintenance the ventilation system	ween 9:00 AM and 11:30 AM servation and interview with the Director (MO), revealed that em in the 100 and 200 wings, corridor as the supply air for				
K 147 SS=D	facility Maintenance discovery. NFPA 101 LIFE SA Electrical wiring an	ice was confirmed by the e Director (MO) at the time of FETY CODE STANDARD d equipment is in accordance ional Electrical Code. 9.1.2	K 14	47		5/28/14
	Based on observa facility failed to mai	s not met as evidenced by: tion and staff interview, the ntain electrical supply in e requirements of 2000 NFPA		The facility failed to mainta supply in accordance with the requirements of 2000 NFPA1		

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		& MEDICAID SERVICE					0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245319	B. WII				17/2014
	PROVIDER OR SUPPLIER	A CRESCENT		1	STREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO	LL PRI	D EFIX AG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 147	101 - 19.5.1, 9.1.2, deficient practice cresidents.  Findings include:  On facility tour betwon 04/17/2014, Obcircuit breaker pancloset was block  NOTE: Check the composition of the co	1999 NFPA 70, 110-26 ould affect 10 out of 40 ween 9:00 AM and 11:30 servation revealed, that el in 100 wing houseked entire facility for this defictive was confirmed by the Director (MO) at the time	O AM the eping iciency	<b>( 147</b>	9.1.2, 1999 NFPA 70, 110-26. 2. The deficient practice could a out of 40 residents. 3. The Maintenance Director ar Environmental Director have be educated on the need to not blocircuit breaker panel. 4. The ED or designee will commandom audits on the area arouncircuit breaker panel monthly formonths. Results will be communitied the QAPI committee.	een eck the plete and the or three	

Event ID: 11K921



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Golden Livingcenter - La Crescent May 7, 2014 Page 2

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, Program Specialist

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

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Golden Livingcenter - La Crescent May 7, 2014 Page 3 Golden Livingcenter - La Crescent May 7, 2014 Page 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00936	B. WING		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOL	JDDRESS, CITY, S JTH HILL STR SCENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of with the Minnesota Department of with the Minnesota Department of the Minnesota Department of with the Minnesota Department of the Minneso	hether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	compliance with all arule provided at the tag alle number indicated below. It is several items, failure to the items will be considered ack of compliance upon any item of multi-part rule will ament of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/in e licensing orders are	f			

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

(X6) DATE TITLE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	CLIA (X2) MULTIPLE CONSTRUCTION  BER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
00936	B. WING	
GOLDEN LIVINGCENTER - LA CRESCENT	OTREET ADDRESS, CITY, STATE, ZIP CODE O1 SOUTH HILL STREET A CRESCENT, MN 55947	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	JLL PREFIX (EACH CORRECTIV ON) TAG CROSS-REFERENCEI	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)  (X5) COMPLETE DATE
Department of Health orders being submit you electronically. Although no plan of cois necessary for State Statutes/Rules, plea enter the word "corrected" in the box avail text. You must then indicate in the electron State licensure process, under the headin completion date, the date your orders will corrected prior to electronically submitting Minnesota Department of Health.  On April 14, 15, 16, 17 and 18, 2014 surve this Department's staff, visited the above pand the following correction orders are isses Please indicate in your electronic plan of correction that you have reviewed these of and identify the date when they will be consumed in the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules Nursing Homes.  The assigned tag number appears in the following entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column dreplaces the "To Comply" portion of the correction order. This column also include findings which are in violation of the state after the statement, "This Rule is not met evidence by." Following the surveyors find are the Suggested Method of Correction at Time period for Correction.  PLEASE DISREGARD THE HEADING OF FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." APPLIES TO FEDERAL DEFICIENCIES of	rrection ase able for nic g be to the eyors of provider ued. rders, inpleted. nentinging s for far left ene umn ne es the statute as ings and et THE	

Minnesota Department of Health STATE FORM

_	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00936		B. WING		04/	18/2014
GOLDEN LIVINGCENTER - LA CRESCENT 101 SOU				DRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
	PLAN OF CORREC	QUIREMENT TO SUB CTION FOR VIOLATION E STATUTES/RULES	ONS OF				
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	n	2 265			
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	ast develop and implement decisions to consult an assistants, and nurely known, notify the residence or an interested familiant's acute illness, serulated the medical director must be involved in the policies. The policies address at least the tion times for:	It rse ident's ily ious rector of or or an he				
		involving the resident has the potential for on;					
	physical, mental, o example, a deterior	change in the resider r psychosocial status, ation in health, menta in either life-threaten al complications;	for al, or				
	example, a need to	ter treatment significa discontinue an existin adverse consequenc f treatment;	ng form				
	D. a decision t resident from the no	o transfer or discharg ursing home; or	e the				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/	18/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR SCENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	E. expected an	d unexpected resident deaths				
	by: Based on observati review, the facility fa low blood sugar lev (R3) who is diabetic blood sugars.  Findings include: R3's signed physici indicated that the re 3/26/10. According note dated 3/5/14 re history of hypoglyce Diabetes type 1 (ins disease requiring di	ure disorder, and major				
	The 30 day Prosper Minimum Data Set a BIMS (brief interview which indicated that R3's signed physici included: for blood GlucoBurst (glucos 15-30 minutes. For scheduled insulin, if 15-30 minutes. Not greater than 500. A give glucose 1 tube alert medical doctor symptoms of hypog Carbamazepine 30 (insulin) 15 units su Novolog (insulin) 8	ctive Payment System (PPS) (MDS) dated 3/28/14 indicated iew mental status) score of 15 t R13's cognition was intact. an orders dated 3/5/14 sugars (BS) 60 give e). Recheck blood sugar in BS greater (>) 400 give f applicable. Recheck BS in tify MD of BS less than 50 or another order also stated to gel by mouth for BS 50 and r. May or may not have plycemia; Abilify 45 mg daily, 0 mg twice a day; Lantus bcutaneously (SQ) every day, units SQ at lunch; and before meals. Resident also				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00936	B. WING		04/1	8/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLDEN	LIVINGCENTER - LA	CRESCENT 101 SOUT	H HILL STR	EET		
GOLDEN	LIVINGCENTER - LA	LA CRES	CENT, MN 5	5947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 4	2 265			
	had orders for a slic blood sugar level set to be given before in The electronic vital 4/15/14 at 5:30 p.m mg/dl (milligrams per note dated 4/15/14 R3 had no insulin the and requiring Glucobeginning of shift. That the physician was usar. On 4/10/14 45 and Glucose gel was no documentat notified of the low b 5:15 a.m. R3's blood According to the codialysis there was a that R3's blood sugdocumented that G that R3 ate a small when rechecked. L Please make sure a documentation that notified. The Assistant Direction an interview on 4/16 R3 had a low blood that she had looked was notified and co During an interview at 8:00 a.m. when a to be called for a low typically he would e treatment for the low stated he didn't known and sometimes when hospital and the enceptions are supported by the stated of the low stated of the low stated of the low stated of the low stated in the low stated of the low stated of the low stated in t	ding scale insulin (based on et amount of insulin is given) meals and at bedtime. signs report indicated that on . R3 had a blood sugar of 37 er deciliter). The nurse 's at 10:32 p.m. indicated that his p.m. due to Accucheck low Burst for Accucheck of 37 at There was no documentation was notified of the low blood at 5:08 R3's blood sugar was was given by nurse. There ion that the physician was lood sugars. On 3/8/14 at bd sugar was 37 mg/dl. mmunication book used for a documented note on 3/8/14 ar was 37. Nurse lucoBurst had been given and breakfast and the BS was 186 antus insulin had been given. She eats. There was no the physician had been divented that sugar yesterday, 4/15/14, and for a fax that the physician	2 265			

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936		B. WING		04/	18/2014
NAME OF PROVIDER OR SUPPLIER  STREET AD  101 SOUT			DRESS, CITY, S TH HILL STR CENT, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 265	Physician-D stated resident had a low I would treat it and the notified even if the I above 50.  A policy titled Diaber revised 2013, indicated as blood glimg. Whenever a ghypoglycemia (70 oprovided immediate of diabetes have armonitoring. Medicated parameters in placed hypoglycemic even diabetic resident guphysician would be glucose.  Suggested Method nursing (DON) or dimedical director to procedures for whe	he would expect that blood sugar that the men he would want to blood sugar had gone etes Management Guated that hypoglycem ucose less than or eclucose test indicates or less) treatment shoely. Residents with a morder for blood glucal doctor (MD) notificate, glucose gel are used to the control of the contr	nurse be e up  lideline, nia was qual to 70  ould be diagnosis ose ation ed for ement of t the by blood  director of with the lian of	2 265			
	staff. The DON or audits of resident rephysician had been	dent, and then could designee could also ecords to determine in notified as appropriativection: twenty-one	perform f the ate.				
2 302	or related disorder to ALZHEIMER'S DIS DISORDER TRAIN	EASE OR RELATED		2 302			
	MN St. Statute 144 (a) If a nursing facil	.6503 ity serves persons w	ith				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/18	8/2014	
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE	_		
GOLDEN LIVINGCENTER - LA CRESCENT			SOUTH HILL STE RESCENT, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 302	Alzheimer's disease or related of segregated or generated and their supervisor care.  (b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	disorders, whether in a eral unit, the facility's directors must be trained in demonstrations include: of Alzheimer's disease and activities of daily living; g with challenging behaviors	entia s; ic				
	by: Based on interview staff training for Alz education. Findings include: Review of the facili CMS 672 revealed diagnosed with der p.m., documentation nursing dated 11/2 record topic: committee dementia, the education in the staff of the	ent is not met as evidence the facility failed to provide theimer's and related dementation provided from the facility had 19 resident mentia. On 4/15/14, at 3:30 on provided by the director 1/13, revealed in-service municating with the elderly, cation lacked information the or of Alzheimer's disease	e entia m s of				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
			A. BUILDING:			
		00936	B. WING		04/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	related disorders, a daily living, problem behaviors. During in p.m., the director of SUGGESTED MET director of nursing of direct care staff and work with persons of This should at a mit Alzheimer's disease assistance with act solving with challen communication skill.	dissistance with activities of a solving with challenging atterview on 4/16/14, at 12:50 for nursing verified the above.  THOD OF CORRECTION: The per designee could in-service all designed the service could be a service could be	2 302			
2 560	Plan of Care; Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The compassessment include the increquired by Minnes subdivision 14, para This MN Requirements. Based on observation review, the facility finterventions in reg symptoms of seizur	of plan of care. The n of care must list measurable stables to meet the resident's n goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560			

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED	
		00936	B. WING		04/1	8/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOI DEN	I LIVINGCENTER - LA	CRESCENT 101 SOUT	H HILL STR	EET			
OOLDLI	EIVINOOEIVIER - EF	LA CRESO	CENT, MN 5	5947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 8	2 560				
		e plan for one of one resident nosed as having seizures.					
	Findings include:						
	the risk factors and activity related to hy R3's comprehensive reviewed and did not seizures, possible anti-seizure medicined to immediated symptoms to the nuresident if they have R3's signed physicindicated that the reading note dated 3/5/14 rehistory of hypoglyce Diabetes type 1, enequiring dialysis, publicated that R3 requiring dialysis, publicated that R3 remg orally twice a disciplination of the documented the product of profound hy The Director of Nurunable to provide a During a phone call she did not have a	e care plan dated 4/22/11 was of address signs or symptoms e adverse side effects of the ne, to alert care givers of the y report these signs and urse and how to protect the e a seizure.  an's order dated 3/5/14 esident was admitted on to the physician's progress esident's diagnoses included: emia (low blood sugar), d-stage renal disease aranoid schizophrenia, seizure depressive disorder. an orders dated 3/5/14 eceived carbamazepine 300 ay due to having a history of in the emergency room due to ome and R3 was discharged emergency physician ncipal diagnosis was seizure coglycemia.  sing (DON) on 4/18/14 was specific care plan policy.  In 4/22/13 the DON stated care plan policy.					
	The director of nurs	HOD OF CORRECTION: sing could inservice all staff eloping care plans to include					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/1	8/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S T <b>H HILL STR</b> CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 9	2 560			
	all interventions needed for the resident.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care I personnel involved in the 				
	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:					
	indicated that the re 3/26/10. According note dated 3/5/14, I history of hypoglyce Diabetes type 1, en requiring dialysis, p disorder, and major The 30 day Prosper Minimum Data Set indicated a BIMS (b score of 15 which ir was intact. The ME	an's order dated 3/5/14, esident was admitted on to the physician's progress R3's diagnoses included: emia (low blood sugar), d-stage renal disease aranoid schizophrenia, seizure depressive disorder. ctive Payment System (PPS) (MDS) dated 3/28/14, orief interview mental status) adicated that R3's cognition DS indicated that R3 required th transfers, dressing and toilet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		04/1	8/2014
NAME OF PROVID	DER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLDENIIIVIN	ACCENTED I A	CRESCENT 101 SOUT	H HILL STR	EET		
GOLDEN LIVIN	NGCENTER - LA	LA CRESC	CENT, MN 5	5947		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
use. R3, ishe Satu a.m. back R3's of all dependence of the sweath irritation of a sweath ir	interviewed on had dialysis on ardays. R3 stat, eats breakfas at the facility for care plan date teration in blooked sugar) episocodes. The interpower blood sugar ating, change ir bility, fruity breakbling, difficulty dedness. Reposician parameter electronic vital /14, at 5:30 p.m. mad no insulin the physician war. On 4/15/14, ad no insulin the physician war. On 4/10/14 Glucose gel war. On 4	4/15/14, at 4:00 p.m., stated Tuesday, Thursdays and ed that she leaves around 6 to before leaving, and arrives for lunch.  d 4/22/11, identifies a problemed glucose due to insuling mellitus, hyperglycemic (high des, and hypoglycemic rventions included to observe symptoms - flushed face, and usual mental status, lethargy, at hodor, coma, nervousness, concentrating, light for abnormal results per ers/guideline.  signs report indicated that on the number of the number of the number of the number of the low blood at 5:08 R3's blood sugar was as given by nurse. Again there the tion that the physician was lood sugar was 37.0 mg/dl. unication book had a note on bood sugar was 37. Nurse ucoburst had been given and breakfast and the BS was 186 antus given. Please make re was no documentation that	2 565			

Minneso	ita Department of He	aith				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
		LA CRES	JENI, WIN J	J941		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 11	2 565			
	and that she had lo physician was notifit R3's physician (P)-I 9:30 a.m., stated the reference to BS of thim at that time but doctor. On 4/17/14 would expect to be the low blood sugar didn't know what the sometimes when rehospital and the enkind of confusing. Fafter licensed staff sugar even if the ble 50 after being treated A policy titled Diaber revised 2013, indicated that blood glimg. Whenever a ghypoglycemia treated immediately. Residuabetes have an omonitoring. MD nor glucose gel is used acute management indicated that the produced by blood glices and the produced to follow the research that the produced to follow the research was not to follow the research that the produced t	oked for a fax that the ed and could not find one. D, interviewed on 4/16/14 at at if it was that low (in 137) they would not have called would have called the on call at 8:00 a.m., P-D stated he notified after the treatment for was done. P-D stated he current order was, esidents come back from the docrinologist writes orders it is 2-D expected to be notified treated the patient's low blood od sugar had gone up above ed. Ites Management Guideline, ated that hypoglycemia was accose less than or equal to 70 lucose test indicates ment should be provided lents with a diagnosis of order for blood glucose tification parameters in place, for hypoglycemic events. An of diabetic resident guideline hysician would be notified as				
2 685	(21) days.	5 Subp. 2 Transfer, Discharge,	2 685			
	and Death	, , , , , , , , , , , , , , , , , , , ,				
	Subp. 2. Other disc	charge. When a resident is				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00936		B. WING		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT	101 SOUT	H HILL STR		, , ,	
GOLDLI	LIVINOOLIVIER - EA	CONLOCENT	LA CRES	CENT, MN 5	5947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 685	Continued From pa	ge 12		2 685			
	transferred or disch than death, the nurs discharge summary time of transfer or o or discharge, transf and condition.	sing home must co that includes the discharge, reason f	ompile a date and for transfer				
	This MN Requirements by: Based on interview failed to complete a recapitulation of star R53, R67, R2) who facility.	and record review a discharge summa by for 4 of 5 resider	, the facility ary and nts (R61,				
	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 documented a discriminary discriminar	harge plan for R61 charge summary d 61 was discharged	. The lated d to home,				
	No physician discha summary or recapit in the medical reco	ulation of the stay					
	R53 was admitted of 11/13/13. Nursing n R53 was discharge had signed a dischardiscomfort and took	otes on 11/13/13 indictes on 1	ndicated nter. R53 nied pain or				
	The interdisciplinary	y discharge summ	ary dated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		04/1	8/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S FH HILL STRI CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 685	11/13/13 did not incidischarged to and cof stay.  R67 was admitted to discharged on 3/1/2 wrote orders that R home on current m documentation on 3 discharged to home medication orders in Nursing documented questions or concernation or con	dicate where the resident was did not include a recapitulation to the facility on 2/17/14 and 14. On 2/28/14 the physician 67 could be discharged to edications. The nursing 3/1/14, indicated R67 was a with the family and that the were faxed to the pharmacy. The resident denied any regarding discharge order. We discharge summary dated for was admitted on 2/17/14 but the facility on 3/5/13 and 1/13. Nursing notes of 3/14/14 or order ge was found in the medical es of 3/17/14 documented for was reviewed. R2 and thone. No written order ge was found in the medical es of 3/17/14 documented for was were reviewed with R2 and thons was reviewed. R2 and the mass and the resident. The facility on the resident. The scharge Summary dated was admitted from Winona ged to home. No recapitulation ented.  Sing (DON) interviewed on				
		m., stated there should be a ay for each resident as well as				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/18	8/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOL	DDRESS, CITY, S JTH HILL STR SCENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 685	discharge orders. 11:27 a.m., there we R61, R53, R67 and there were no writte for R61, R53 and R SUGGESTED MET director of nursing oneed to do a discharthe regulation/order	The DON stated, on 4/17/14 as no recapitulation of stay fo R2. The DON also stated en physician discharge orders 2.  THOD OF CORRECTION: The could inservice staff on the arge summary as outlined in	· ·			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and home resident must be outpossible unless there is a the attending physician that the in in bed or the resident	d t			
	by: Based on observati review, the facility for to episodes of low be	ent is not met as evidenced on, interview and record ailed to respond appropriately blood sugar for 1 of 1 resident htly hospitalized for a seizure I sugar.				

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00000	B. WING		0.444	0/004.4
		00936	B. WING		04/1	8/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOI DEN	LIVINGCENTER - LA	CRESCENT	H HILL STR			
OOLDLIN	EIVIITOGENTER EA	LA CRESO	CENT, MN 5	5947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	Findings included: R3's physician progindicated diagnoses hypoglycemia (low lend-stage renal disseizure disorder. The hospital dischaindicated R3 was troprofound hypoglythe facility. The surhypoglycemia remablood glucose shou higher side. R3's signed physiciancluded treatment follows: For bloods Glycoburst. Recheminutes. For BS grinsulin, if applicable minutes. Notify MD than 500. Another gel by mouth for BS may not have symp The 30 day Prosped Minimum Data Set a BIMS (brief intervity which indicated that The MDS indicated assistance with trar R3's care plan date of alteration in blood dependent diabetes blood sugar) episode pisodes. The interfor low blood sugar sweating, change in	iress note dated 3/5/14, is that included: history of blood sugar), Diabetes type 1, ease requiring dialysis and irge summary dated 2/28/14, eated following a seizure due ocemia (low blood sugar) at inmary indicated that ined a huge concern and R3's ld be allowed to run on the interest and an orders dated 3/5/14 for hypo/hyperglycemia as sugars (BS) less than 60 give included included in the interest and allowed to run on the interest and allowed in the interest and in	2 830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I LAN OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COIVII	LLILD
	00936	B. WING		04/1	8/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	101 SOUT	H HILL STR	EET		
GOLDEN LIVINGCENTER - LA	LA CRESC	CENT, MN 5	5947		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830 Continued From page	ge 16	2 830			
The electronic vital situation 4/15/14 at 5:30 p.m. mg/dl (milligrams per dated 4/15/14 at 10: no insulin this p.m. or requiring Glycoburst beginning of shift. That the physician was sugar. On 4/10/14 at was 45. Glucose gethere was no docum was notified. On 3/8 sugar was 37.0 mg/c communication book indicated Glycoburst ate a small breakfast rechecked. There was physician had been The assistant direct interviewed on 4/16/R3 had a low blood she could not find an was notified.  R3's physician (P)-D 9:30 a.m., stated the should have been could have been could nate that should have been could stated she received Thursdays, and Satue ats breakfast befor and returns before least breakfast breakfast breakfast breakfast breakfast break	signs report indicated that on R3 had a blood sugar of 37 or deciliter). The nurses note 32 p.m. indicated that R3 had due to Accucheck low and for Accucheck of 37 at there was no documentation as notified of the low blood to 5:08 p.m. R3's blood sugar el was administered; however, the the thick that the physician R3/14, at 5:15 a.m. R3's blood and according to the dialysis of the R3 was 186 when as no documentation that the notified. For of nursing (ADON)-B, 14 at 9:30 a.m. stated that sugar yesterday, 4/15/14, but the evidence the physician on the the or the on-call physician on the theoretical physician on the theoretical sugar yesterday, 4/16/14 at 19:30 a.m. and dialysis on Tuesday, and yes R3 stated that she e leaving around 6:00 a.m.	2 830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING.			
		00936	B. WING		04/1	8/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	and recheck and the below 50 or above change today, she physician to let him level.  On 4/17/14 at 7:00 Pharmacist (RP)-Could be related to example the antips blood sugar levels. Physician (P)-D, into a.m., stated he would want blood sugar had go A policy titled Diaberevised 2013, indicate defined as blood glimg. Whenever a ghypoglycemia treat immediately. Residuabetes have an omonitoring. MD no glucose gel is used SUGGESTED MET The director of nurs the need to provide resident.	O they are to give the glycogen ten call the physician if still 400. LPN-B stated before the would have called the know of the low blood sugar a.m. the Registered stated that hypoglycemia R3's other medications, for yehotic Abilify could cause low terviewed on 4/17/14 at 8:00 uld expect that if a resident gar the nurse would treat it and to be notified even if the	2 830	BEHOLING		
2 910	Incontinence	5 Subp. 5 A.B Rehab -	2 910			
	have a continuous	nce. A nursing home must program of bowel and bladder duce incontinence and the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING		04/1	8/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DDRESS, CITY, S TH HILL STR SCENT, MN 5		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	unnecessary use of comprehensive reshome must ensure A. a resident without an indwelling unless the resident' that catheterization B. a resident where receives appropriate prevent urinary trace	catheters. Based on the ident assessment, a nursing	2 910			
	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 was alert and orient During an interview stated she was indecares. During an in a.m., nursing assist independent, but the	on 4/14/14 at 9:30 a.m. R59 ted, reading the newspaper. on 4/15/14 at 9:27 a.m., R59 ependent with most of her nterview on 4/18/14 at 9:45 ant (NA)-A stated R59 was at staff would help with requested the help.				
	Keflex (antibiotic) 2 for prevention of UT documentation of 3 of chronic bronchitis	cian orders of 3/14/14 included 50 mg by mouth at bedtime II. The physician /5/14 indicated a problem list s, history of depression, rinary tract infections and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936		B. WING		04/	18/2014
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	A CRESCENT		TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCI Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 910	history of diverticulian Physician documer recurrent urinary tranoted R59 did not cand to continue with monitor for recurring physician document R59 had a recurrent had no discussion of the bladder assess indicated R59 was was no document aphysical abnormality post void residuals evaluate R59's risk infections or that shapprophylactically. Not assessment or evaluate R59's risk infections or that shapprophylactically. Not assessment or evaluate R59's risk infections or that shapprophylactically. Not assessment or evaluate R59's risk infections or that shapprophylactically. Not assessment or evaluated R50's required supervision hygiene, was continuated supervision hygiene, was continuated personal hygiene, was continuated personal hygiene, assessment (CAA). The care plan print required personal hygiene, indicated a propellimination of bower	ntation of 3/6/14 indicated infections. The particular	chysician ne antibiotic iotic and ew of the dicated tion, but nfection.  /3/14 r. There for any is or any form did not tract hilly dder The lated f interview vely intact, eting and ot had a  d R59 of one and The care alteration in o history of				
	UTI and to provide to use briefs/pads f	and report signs/sy assistance of one to for incontinence prosing (DON) was into DON stated R59	o toilet and tection.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		04/1	8/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 910	Continued From page 20		2 910			
	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.					
	independently utilize therapy room. At 9 stated R71 was mo cares but required s as needed. NA-C s	on 4/18/14 at 9:40 a.m. ing the exercise bike in the 244 a.m. on 4/18/14 NA-C stly independent with perineal stand by assistance and help stated staff set her up for ares and that R71 would ask ers.				
	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.					
	history of recurrent antibiotics at bed tir 8/29/13 indicated re prophylactic Trimet bedtime. Physician	d 2/21/13 stated R71 had a UTI and was on prophylactic me. Urology note dated ecurrent UTI and use of hoprim (antibiotic) 50 mg at orders dated 4/1/14 include g by mouth at bedtime for act infections.				
	not address recurre	ry care plan in place that did ent UTIs or assistance needed liene. A bladder assessment				
	director of nursing s for a UTI following a stated a urinary trac been completed.	on 4/18/14 at 9:10 a.m. the stated R71 had been treated admission. At 9:40 a.m. DON at risk assessment had not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00936	B. WING		04/1	18/2014
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
COLDEN	LLIVINGCENTED L	A CRESCENT 101 SO	UTH HILL STR	EET		
GOLDEN	I LIVINGCENTER - LA	LA CRI	SCENT, MN 5	55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	age 21	2 910			
2010	in the lobby reading interviewed at 9:44 R11 required total a and required exten	g a newspaper. NA-C was a.m. on 4/18/14 and stated assistance with perineal cares sive assistance with transfers	S			
	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.					
	R11 was incontiner some daily control, antidepressant, and	nent dated 8/23/13 indicated int of bladder but may have received diuretics, was on and d had mild dementia. The ied stress urinary incontinence				
	The form did not in any physical abnor or any post void res	dicate R 11 was assessed fo malities, and recent urinalysis siduals. The assessment for I1's risk to develop urinary tra	r s, m			
	dated 4/18/14 for u	The care area assessment urinary incontinence noted der due to nerve damage				
	had a BIMS score of required extensive personal hygiene, whad a UTI in the pa	•				
	of physical function	ed 3/13/14 identified a proble ning deficit that directed staff assistance of one for persona				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		04/1	18/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	hygiene and toiletin and change every 2 care plan printed 3/ alteration in elimina bladder with interve and report signs an provide assistance During an interview DON stated R11 last that a urinary tract i not been completed had seen a urologis primary physician b information was provided as a provided as a urologis primary physician b information was provided as a urologis primary physician b information was provided as a urologis primary physician b information was provided as a urologis primary physician b information was provided as a urologis primary physician be information was provided as a urologis primary physician beathroom without wash her perineal a episodes.  R45 was admitted on the bathroom without wash her perineal a episodes.  R45 was admitted on the bathroom without of 3/5/14 listed disease and incontion of 5/2/13 noted R45 overactive bladder) for UTI prophylaxis 3/5/14 included Trir bedtime  The bladder assessing incontinence with left frequently. The assessing physical all or post void residual evaluate R45's risk infections or that shift frequently in the significant provided as a possible physical all or post void residual evaluate R45's risk infections or that shift frequently in the significant provided as a possible physical all or post void residual evaluate R45's risk infections or that shift provided and the provided as a pro	g assistance of one to check 2 hours and as needed. The 13/14 identified a problem of a problem	2 910			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From page 23		2 910			
	did not evaluate the risk. The quarterly MDS BIMS score of 6 or frequent incontinen and personal hygie days. The care plan for p printed 3/15/14 dire assistance of one a care at least once of printed 3/15/14 ider of bowel and bladd incontinence and d signs and symptom During an interview	on 4/18/14 at 9:30 a.m. the last UTI was in May 2013 and				
	The director of nurs responsible for urin to address all incor	THOD OF CORRECTION: sing could inservice staff ary incontinence on the need attinence needs.  R CORRECTION: Twenty One				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	This MN Requirem	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/1	8/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	by: Based on observation review the facility far procedures during to of 2 residents (R43 failed to implement possible spread of immonitoring observation who had blood sugar Findings Include: R43 was observed change to the foot of licensed practical nexam gloves to remain the area with wound gloves and went to an opened box of to R43's over the bed gloves and applied applied a sterile teleright hand. She the sitting on the over the right hand, cut the pocket using her right pocket using her right pocket using her right thand, cut the box and stated to the storage close.  The director of nurse 4/16/14 at 10:30 a. If gauze should not he storage closet. DO were to be kept in the dressing was to use dressing should be	on, interview, and record alled to maintain sanitary wound dressing change for 1 or reviewed for wound care; procedures to prevent the affection during blood glucose tions for 1 of 2 resident (R18) ars taken.  during a wound dressing on 4/16/14 at 10:12 a.m. with the urse (LPN)-A. LPN-A used allowed the dressing and clean dicleanser. LPN removed her the supply cupboard to obtain abular gauze which she sat on table. LPN-A put on clean a new dressing. LPN-A both a pad to the area with her en took tube gauze that was need table out of the box with the gauze with a scissors from the part of the table. She applied the strength of tube gauze into she was going to take it back	21375			

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		00036	B. WING		04/4	0/204.4	
		00936			04/1	8/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5				
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE	
21375	Continued From pa	ge 25	21375				
	now contaminated.						
	a blood glucose lev was observed to ch which RN-A had glo discarded the used out of the glucomet end of strip sticking sharps container had RN-A had then carr hallway to the medi glucometer on the rhad not been clean hands and proceed medications. Surve the time with RN-A cleaned. RN-A had put it away." RN-A each medication cabetween residents a alcohol pad to clear proceeded to pick ugloves on and clear alcohol pad. RN-A gloves on when clear alcohol pad. RN-A gloves on and clear alcohol pad.	medication cart (glucometer ed), removed gloves, washed ed to start setting up to pass yor intervened and verified at the glucometer had not been stated, I won't clean it until I stated only one glucometer for art, the glucometer is shared and had stated uses an in the glucometer. RN-A had up the glucometer without in the glucometer with an verified at the time had no aning the glucometer and had do to clean the glucometer. meter had not been sanitized immended to kill blood bourne.  4/16/14, at 1:00 p.m., director ed she would expect policy to be wipe for cleansing for one of states for cleaning the ves are to be worn when					
		f facility policy GLUCOMETER DN dated 12/2/13, read					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00936	B. WING		04/1	8/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE
21375	Continued From pa	ge 26	21375			
	"PURPOSE: To improcess for decontary Dispatch wipes will disinfectant. This is tuberculocidal; effects broad spectrum of the based and meets recequipment for Clost Dispatch is not avaimated be decontaminated use on each reside manufacturer's reception of the second of	blement a safe and effective aminating glucometers. be used as a Glucometer	21010			
	The director of nurs	sing could inservice all staff on of infection control to prevent				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 4 Tuberculosis ntrol	21426			
	maintain a compreh	e provider must establish and nensive tuberculosis ogram according to the most				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	A CIRESCIENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21426	current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements	s infection control guidelines of States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). Include a tuberculosis on that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.	21426			
	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).					

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21426	in the medical reco documented that R skin test (TST).  RN-A had a hire da review of facility em records revealed la skin test administer received before hire of 5/1/13. Docume tuberculin skin test evidence of tubercu LSW-A or previous.  During an interview (DON) on 4/18/14 sequested for 5 stat documentation of toconfirmed that 2 of 5 residents did not tuberculosis testing DON was unable to on 4/18/14 when as 2:52 p.m. the DON documentation that completed.  The policy titled Tul Plan, guidelines for and new hires date admissions, new as receive a 2-step Matuberculin units-intered on ad Method of Complia following measure of the skin test of the	ge 28 sis screening was not evident rd and there was no evidence 8 had received the tuberculin te of 9/25/13. Document aployee tuberculin skin test ck of evidence of tuberculin red for RN-A or previously e date. LSW-A had a hire date of the review of facility employee records revealed lack of allin skin test administered for y received before hire date.  with the Director of Nursing 2:49 a.m. documentation was ff and 5 residents for aberculin testing. The DON the 5 employees and 2 of the have documentation that had been completed. The provide a Risk Assessment sked and then on 4/22/14 at stated she could not find the a TB Risk Assessment was a TB Risk Assessment was concerned and volunteers antoux PPD Test (.1 ml of 5 and 1998 indicated that all new associates, and volunteers antoux PPD. Step 1 was to be mission/or on hire. Under noce, it indicated that the would be implemented: essment (baseline and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S FH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 29 sessment category).	21426			
	director of nursing or responsible for TB of	HOD OF CORRECTION: The could inservice all staff on the most current standards in regards to TB control.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21530	A. The drug regim reviewed at least m currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is incompared available through the system. It is not sue B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pure upon means the acreport and the significant of nursing services C. If the attend with the pharmacist not provide adequat pharmacist believes	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next poner, if indicated by the rposes of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. Ing physician does not concur's recommendation, or does the justification, and the steresident's quality of life is ected, the pharmacist must	21530			

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		00936	B. WING		04/1	8/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	if the medical direct physician. If the medical medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the mattrassessment and assessment and assessm	he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter review to the quality surance committee required of the attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.	21530			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	R56's current physi revealed an order for anti-anxiety medical eight hours as need oxycodone-acetam 5-325 mg one to two for pain, do not excindication on physic give one tablet or two medication) 650 mg PRN for pain.  During review of R5 records the followind dates of 3/17/14 through 4/16 doses of PRN ordoses of PRN Tyler 4/1/14 through 4/16 doses of PRN loraz oxycodone-acetam Tylenol. R56's progogethrough 4/16/14 ide was not clearly ider it was given.  During interview on Assistant director ophysician orders lacoxycodone-acetam or two tablets.  During interview on Assistant director ophysician orders lacoxycodone-acetam or two tablets.	ge 31 cian orders dated 3/38/14, or lorazepam (Ativan) (an tion) 0.5 mg (milligrams) every ded (PRN) for anxiety, inophen (a pain medication) o tabs every four hours PRN eed 12 tablets per day (no cian orders identified when to two tablets) and Tylenol (a pain g once a day at HS (bedtime)  66's medication administration g had been noted: from the rough 3/31/14 R56 had had 8 doses of PRN lorazepam, exycodone-acetaminophen, 3 hol and from the dates of 6/14 R56 had received 14 repam, 24 doses of PRN inophen, one dose of PRN ress notes dated 3/17/14 entified the use of the Ativan hitfied as to parameters to why  4/17/14, at 2:25 p.m., f nursing verified R56's cked parameters for PRN inophen of when to give one  4/17/14, at 2:59 p.m., Director R56's physician orders lacked N oxycodone-acetaminophen er two tablets. On 4/17/14, at of nursing state she would charmacist to have identified in-pharmacological measure				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00936	B. WING		04/	18/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOL	DDRESS, CITY, S ITH HILL STRE SCENT, MN 55	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Document review of substance prescription: 13) PF delineate the conditional administered, for experience of severe pain (pain some for sleep. "Facility only page one of formal state, generalized patterns of the state of the s	of the facility policy controlled tions dated revised 11/11, reactments of controlled substance (RN (as needed) orders clearly tion for which they are being example, "as needed for cale 7-10), "or "as needed director of nursing provided ur of policy.  Deva an antidepressant without a promote to monitor if it was ders dated 4/16/14 indicated ted on 7/11/13 with diagnoses mited to: delusional disorder, avioral disturbance, anxiety pain and chronic kidney oderate).  The all Data Set (MDS) dated that R19's BIMS (brief atus) was 9 out of 15 indicating tely impaired.  The R19's physician orders dated ated that R19 received Celexal ay for anxiety state.  The archive and that R19 had the gns and symptoms of mood all indicated that R19 would talks and happy memories during				

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00936	B. WING		04/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
001.054	LLIVINGOENTED LA	ODECCENT 101 SOUT	H HILL STR	EET		
GOLDEN	I LIVINGCENTER - LA	LA CRESC	CENT, MN 5	5947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 33	21530			
21530	sad. A second probable that there was a pocomplications asso psychotropic medicantidepressant medicantidepressant medicantidepressant medicantidepressant medicantidepressant medicantidepressant medicantidepressant medicantidepressant report to signs/symptoms of self to room, makindocument. Report Monthly pharmacy Provide non-pharm with family and frier bingo and music preservation. During observation 4/16/14 at 7:29 a.m walking out of the bassistant. R19 stat and moving around 4/16/14 at 8:13 a.m room and was observation and was observation 4/16/14 at 1:08 p.m displayed her anxious that she would get and not wanting to were no comments associated with it. During an interview p.m. when asked all moods, LPN-A state the hallucinations with the use of the antid During an interview with use of the antid During an interview.	plem dated 8/2/13 indicated tential for drug related ciated with the use of ations related to dication. Interventions for pain, monitor for side or physician, monitor for depression including isolating gregative statements and changes to physician. The review of medication regimen. The accutical interventions of visits and activities like or and interview with R19 on and interview with R19 on and interview with R19 on and interview with a nursing ed it's better once she gets up. During observation on R19 was out in the dining erved laughing and conversing and the administrator. The arising assistant (NA)-D on and the administrator. The about mood or symptoms with LPN-A on 4/17/14 at 2:15 bout R19's behaviors or ed that she didn't know what were, and LPN-A stated that that R19's symptoms were for epressant. With the Director of Nursing	21530			
	were no comments associated with it. During an interview p.m. when asked al moods, LPN-A state the hallucinations with the use of the antid During an interview (DON) on 4/17/14 a	about mood or symptoms with LPN-A on 4/17/14 at 2:15 bout R19's behaviors or ed that she didn't know what vere, and LPN-A stated that hat R19's symptoms were for epressant.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00936	B. WING		04/1	8/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	A CRESCENT	TH HILL STR SCENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	delusional disorder DON stated that Raroom. A review of the behaling problem of Rasing and depressed withdraw hallucinations/para code. Mood chang Documentation indexcept one time in depressed/withdraw indicator. The quarterly interedated 3/12/14 underindicated none, with Marked anxious at quantitative behavion No policy on target after being request.  Rareceived an ant there were no clear specific to this reside the antidepressant Ra's physician orders and Rawas admitted or including: senile dedepressive disorder. The quarter MDS of BIMS score was 9 cognition was moded the physician's order Rawas receiving Zadepressive disorder. Rayas receiving Zadepressive disorder.	T. For R19's depression, the 19 would not come out of her would not come out of her avior monthly flow sheet for March of 2014, indicated that wn and noia/delusion was the behavior ges were not being monitored. Iicated no behaviors observed February 2014 for wn with no individualized mood disciplinary resident review er behavioral symptoms he the use of an antidepressant times, with no individual or or documented. ed behaviors were provided red on 4/18/14.  Itidepressant medication yet remood symptoms/signs dent identified to determine if was affective or not. ers dated 4/1/14 indicated that n 11/26/05 with diagnoses ementia, hemiplegia, er, and generalized anxiety dated 3/20/14 indicated R8's out of 15 which indicated erately impaired. der dated 4/1/14 indicated that 20loft 50 mg every day for				
	a problem of R8 fer lonely, angry. No identified.	eling sad and restless, irritable	,			

Minnesota Department of Health

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		04/18/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOI DEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
		LA CRESO	CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From page 35		21530			
	while watching TV pretty good and she During observation R8 was in the dining behaviors of yelling A review of the beh February, March, at R8's behavior code screaming/yelling. changes were ident During an interview when asked how RNA-D stated that Rout, and is irritable symptoms associat During an interview about how R8 displ stated that she had out and did not kno behaviors. During an interview (DON) on 4/17/14 at that a long time againappropriate behav with yelling out. The mood.  SUGGESTED MET The pharmacist or othe requirements for medication.	with nursing assistant (NA)-D 8 displays mood changes, 8 is attention-seeking, yells but had no comments about ed with depression. with (LPN)-A, when asked ays mood behaviors LPN-A never seen R8 scream or yell w any identified mood with the Director of Nursing at 2:30 p.m., the DON stated				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		04/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	A CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	Continued From pa	age 36	21535			
	must be free from unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without ade D. in the prese which indicate the odiscontinued. In addition to the odiscontinued in the odiscontinued. In addition to the odiscontinued in the odiscont	quate indications for its use; or ence of adverse consequences dose should be reduced or drug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. Corporated by reference. It is ne Minitex interlibrary loan ate Law Library. It is not				
	by: Based on interview facility failed to ider clinical indications medications for 3 c	ent is not met as evidenced and document review, the ntify, assess and monitor for use of psychoactive of 5 residents (R56, R19, R8) essary medications.				
	Findings include:					
	dated 3/28/14, iden closed fracture par neoplasm of breast	on 11/18/13. Physician orders atified diagnoses that included t neck femur, malignant t, anxiety state and depressive trerly Minimum Data Set (MDS)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/ <sup>-</sup>	18/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DDRESS, CITY, S TH HILL STR SCENT, MN 5		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	dated 2/17/14, iden status (BIMS) had be indicated moderate had near constant properties one to ten and no be scheduled pain medication and not pain.  R56's current physical revealed an order for anti-anxiety medical eight hours as need oxycodone-acetaming 5-325 mg one to two for pain, do not excindication on physical give one tablet or two medication) 650 mg PRN for pain.  During review of R5 records the following dates of 3/17/14 through 4/16 doses of PRN ordoses of PRN to doses of PRN lorazion oxycodone-acetaming Tylenol. R56's progent trough 4/16/14 identity was given.  During interview on Assistant director or physician orders lacetaming the properties of the physician orders lacetaming the properties of the progent oxycodone oxyco	ge 37  tified brief interview of mental been 12 out of 15 and cognitive impairment. R56 pain rated eight on the scale of ehaviors. R56 received dication, PRN (as needed) in-medication interventions for cian orders dated 3/38/14, for lorazepam (Ativan) (an tion) 0.5 mg (milligrams) every ded (PRN) for anxiety, inophen (a pain medication) to tabs every four hours PRN eed 12 tablets per day (no cian orders identified when to every four hours and the fough 3/31/14 R56 had had gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)  66's medication administration gonce a day at HS (bedtime)	<b>,</b>			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						) DATE SURVEY COMPLETED	
		00936		B. WING		04/	18/2014
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE	·	
GOLDEN	I LIVINGCENTER - LA	CRESCENT		ENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From pa	ge 38		21535			
	of nursing verified F parameters for PRN of when to give one 3:52 p.m., director of expect consultant p parameters and not concerns.  Document review of substance prescription: 13) PR delineate the conditional administered, for experimental parameters and not concerns.	4/17/14, at 2:59 p.m., ER56's physician orders land oxycodone-acetamino er or two tablets. On 4/17 of nursing state she would harmacist to have identify the facility policy controlled subtemple, as needed for cale 7-10), or as needed for cale 7-10, or as	acked phen 7/14, at uld iffied sure olled 1, read estance clearly eing r				
	for sleep. " Facility only page one of fo	director of nursing prov	ided				
	identified mood syn effective or not. R19's physician ord that R19 was admit including, but not lir dementia with beha state, generalized p disease state III (m	nptoms to monitor if it was ders dated 4/16/14 indicated on 7/11/13 with diagnited to: delusional discovioral disturbance, anxionain and chronic kidney	ated gnoses order, ety				
	3/12/14 indicated the interview mental state cognitively moderate During the review of 4/16/14 it was indicated a problem antidepressant medicated a problem.	nat R19's BIMS (brief atus) was 9 out of 15 inc	dicating s dated Celexa /13 g an ed the				

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Minnesc	<u>ota Department of He</u>	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00936	B. WING		04/18/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
COLDEN	LLIVINGCENTED LA	101 SOL	TH HILL STR	EET		
GOLDER	I LIVINGCENTER - LA	LA CRES	SCENT, MN 5	5947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21535	Continued From pa	ige 39	21535			
	concerns. The goa about positive topic conversations. Interests, help keep friends, to give med depression and matake the time to dissad. A second protothat there was a pocomplications asso psychotropic medicantidepressant medincluded to assess effects and report to signs/symptoms of self to room, makindocument. Report Monthly pharmacy Provide non-pharm with family and frier bingo and music preet up. To decreas depression. During observation 4/16/14 at 7:29 a.m. walking out of the bassistant. R19 stat and moving around 4/16/14 at 8:13 a.m. room and was observation and was observation with family and frier bingo and music preet up. To decreas depression. During observation 4/16/14 at 7:29 a.m. walking out of the bassistant. R19 stat and moving around 4/16/14 at 8:13 a.m. room and was observation	al indicated that R19 would talk es and happy memories during erventions included: evolved in activities related to o in contact with family and dications that help with image any side effects, and to cuss feelings when feeling blem dated 8/2/13 indicated itential for drug related iciated with the use of				

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During an interview with LPN-A on 4/17/14 at 2:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		04/18/2014	
NAME OF			DRESS CITY O	STATE, ZIP CODE	1 0-7/1	0/2014
NAIVIE OF	PROVIDER OR SUPPLIER		H HILL STR	,		
GOLDEN	I LIVINGCENTER - LA	A CIRESCIENT	CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	moods, LPN-A state the hallucinations we she was unclear where the use of the antide During an interview (DON) on 4/17/14 at that R19 was recent delusional disorder DON stated that R19 was recent delusional disorder delusional disorder delusional disorder with depressed with drawind depressed/with drawindicator.	with the Director of Nursing at 2:30 p.m., the DON stated only hospitalized for a . For R19's depression, the 19 would not come out of her avior monthly flow sheet for March of 2014, indicated that wn and noia/delusion was the behavior les were not being monitored, icated no behaviors observed February 2014 for wn with no individualized mood				
	dated 3/12/14 under indicated none, with Marked anxious at quantitative behavior No policy on target after being request.  R8 received an ant there were no clear specific to this reside the antidepressant R8's physician order R8 was admitted or including: senile dedepressive disorder.  The quarter MDS desired.	ed behaviors were provided ed on 4/18/14.  idepressant medication yet r mood symptoms/signs dent identified to determine if was affective or not. ers dated 4/1/14 indicated that in 11/26/05 with diagnoses ementia, hemiplegia, r, and generalized anxiety  lated 3/20/14 indicated R8's out of 15 which indicated				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		04/1	8/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	ACRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	Continued From pa	ige 41	21535			
	The physician's ord R8 was receiving Z depressive disorde The comprehensive a problem of R8 fee lonely, angry. No identified. During an interview a.m., resident was while watching TV pretty good and she During observation R8 was in the dinin behaviors of yelling A review of the beh February, March, a R8's behavior code screaming/yelling. changes were iden During an interview when asked how R NA-D stated that R out, and is irritable symptoms associat During an interview about how R8 displ stated that she had out and did not know the state of the properties of the properties. During an interview (DON) on 4/17/14 at that a long time again in the properties of the propertie	der dated 4/1/14 indicated that coloft 50 mg every day for r. e care plan dated 5/21/11 had eling sad and restless, irritable, mood behaviors were  with R8 on 4/16/14 at 7:05 waiting for breakfast in room R8 stated her appetite was e didn't really like watching TV on 4/16/14 at 8:09 a.m. while g room at a table by self, no out were observed. avior monthly flow sheet for nd April of 2014 indicated that was angry and continuous No individualized mood tified.  with nursing assistant (NA)-D 8 displays mood changes, 8 is attention-seeking, yells but had no comments about the with depression.  with (LPN)-A, when asked ays mood behaviors LPN-A in ever seen R8 scream or yell the wany identified mood  with the Director of Nursing at 2:30 p.m., the DON stated on R8 had sexually viors and has some issues were was no monitoring of				
	The director of nursinservice all nurses	THOD OF CORRECTION: sing/pharmacist could responsible for medication e requirements for use of an				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00936		B. WING		04/	18/2014
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT		TH HILL STR Cent, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 42		21535			
	psychoactive medic	cation.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Tw	enty One				
21615	MN Rule 4658.1340 Preparation Area;So	) Subp. 2 MedicineCa cheduleII	abinet &	21615			
	nursing home must compartments, peri physical plant or me	of Schedule II drugs. provide separately lo manently affixed to the edication cart for storated in Minnesota Stated vivision 3.	ocked e age of				
	by: Based on observati failed to ensure that kit were stored prop rooms and failed to	ent is not met as evice on and interview, the transcotics in the emergerly in 1 of 1 medical ensure expired medion use for 1 of 1 reside	facility ergency tion cation				
	was observed that to contained narcotics secure lock only an separately locked, prompartments, excesingle unit medication which the quantity simissing dose can be	ne medication storage the emergency kit wh were stored under a d are to be stored in permanently affixed ept when the facility u on distribution system stored is minimal and e readily detected; arons are reconciled ac	ich single uses ns in a				
	room storage tour it	p.m. during the medic t was noted that the a tag on it but was no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.			
	00936	B. WING		04/1	8/2014
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
storage room. This nurse (RN)-B.  The Director of Nurse p.m. confirmed this a following was in the Injection 5 mg/ml (V Hydrocodone/Apap Lorazepam 0.5 mg (mg/ml 1 30 ml vial, a tablets.  A policy titled Controdated 05/12 indicated medications and oth abuse or diversion a affixed, double-locked from all other medications and other medications and other medications are diversion as affixed, double-locked from all other medications are diversion as affixed, double-locked from all other medications and other medications are for R1 when it was opened 12/31/12 through Hele expiration date was thought that R12 has admission. RN-B control expiration and did not had been opened.  The physician order R12 was admitted on including senile dem disease, anxiety states esophageal reflux, a quarterly Minimum Expiration of the physician order R12 was admitted on including senile dem disease, anxiety states and the physician order R12 was admitted on including senile dem disease, anxiety states and the physician order R12 was admitted on including senile dem disease, anxiety states and the physician order R12 was admitted on including senile dem disease, anxiety states and physician order R12 was admitted on including senile dem disease, anxiety states and physician order R12 was admitted on including senile dem disease, anxiety states and physician order R12 was admitted on including senile dem disease, anxiety states and physician order R12 was admitted on including senile dem disease, anxiety states and physician order R12 was admitted on including senile dem disease, anxiety states and physician order R12 was admitted on including senile dem disease.	he lock on the door to the was confirmed by registered sing (DON) on 4/17/14 at 3:33 and also confirmed that the emergency kit: Diazepam falium) 1- 10 ml vial. 5/325 mg (Lortab)12 tablets. (Ativan), Morphine Sulfate 20 and oxycodone 5 mg, 12 olled Substance Storage				

Minnesota Department of Health

STATE FORM 6899 11K911 If continuation sheet 44 of 46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		04/1	8/2014
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, STHENDERS, CITY, STHEND STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21615	orders dated 11/12/receive nitroglycerir (SL) as necessary fat 5-minute interval  When discussed wip.m. after the tour opolicy requested, the Process Example: 05/12. This process included that expire contaminated medi removed from their disposed of properlischedule II medical double-locked storal SUGGESTED MET. The director of nurs responsible for med follow guidelines for requirements.	d cognition. A signed standing /13 indicated that R12 could in 1/150 (0.4 mg) sublingual for chest pain. May repeat x 2 s.  ith the DON on 4/17/14 at 3:33 of the medication room and a see DON provided the CQI Medication Storage dated s had a check off list that	21615			
21665	A nursing home mu functional, comforta environment, allowi	O Physical Environment ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.	21665			
	by: Based on observati	ent is not met as evidenced on and interview, the facility cets were clear of calcification				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		00936	B. WING		04/1	8/2014				
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LA CRESCENT  STREET ADDRESS, CITY, STATE, ZIP CODE  101 SOUTH HILL STREET  LA CRESCENT, MN 55947										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE				
21665	build up on bathroo sanitized able surfa whose faucets were build-up. Findings include: An observation on a that bathroom fauce 209, had calcificatio spigot and knobs. A 6:10 p.m. with Main were lime covered a to be replaced. Ma hard water and only  During an environm - D, on 4/17/14 at 9 indicated that the sproom 209 had been confirmed that room faucet with lime cover the sink onto the wain room 205 the bat of the spigot had the turn knobs were pitted.  SUGGESTED MET The maintenance devisual inspection of determine if lime buildecide how to treat.	m faucets to promote a ce for 3 of 5 bathrooms e coated with calcification  4/14/14 at 6:10 p.m. indicated ets in rooms 104, 205, and on of lime built up around An interview on 4/14/14 at tenance-A verified the faucets and felt that they would need intenance-A stated they have the warm water is softened.  The soft and knobs on the sink in a replaced. Maintenance-D on 104 in the bathroom had the vered and the screws holding alls were uncovered. And that throom sink faucet at the end fick lime built up and that the ted.  THOD OF CORRECTION: epartment could include a faucets house wide to utild up is present and then	21665							

## 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).

required, aπach additional sneet(s).									
PROVISION NUMBER(S)	JUSTIFICATION								
K84 K067	A waiver is requested for K067 for the following reasons:								
	1. 2. 3. 4. 5. 6. 7. B. Complian 1. fig	The building has auto the building fire alarm system. Annual service and n alarm, sprinkler system, portable e The building fire alar Fire safety training is Fire drills are conduct The facility is protect ce with this provision would impose	oped with an approved corridor omatic shut down of ventilation naintenance contracts exist to extinguishers)  rm system is monitored to prose provided for all employees of eted at least quarterly on each ted by a supervised automatic et an unreasonable hardship on mated \$ 188,000 to upgrade the facility's electrical system to a	r smoke detection system. on fans/HVAC system upon detection service all the facility's fire protectivide automatic fire department not an annual basis and during orientshift. sprinkler system.  the facility since: the facility's HVAC system to component of the facility's HVAC system to component of the facility's HVAC equipments.	tion systems (for example; fire tification. tation for all new hires.				
Surveyor (Signature)		Title	Office		Date				

Fire Safety

Supervisor

Office

State Fire

Marshal

Title

Fire Authority Official (Signature)

## RON HAMMES REFRIGERATION, INC.

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

## PROPOSAL NoGLC12.20.11

Submitted To:

Phone:

Golden Living Center 101 So. Hill Street

La Crescent, MN 55947

507-895-4445

December 20<sup>th</sup>, 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.

DATE OF ACCEPTANCE

**PURCHASER'S SIGNATURE**