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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 36LS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00872

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245293**
2.STATE VENDOR OR MEDICAID NO.
(L2) **417633200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2002**

6. DATE OF SURVEY **2/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A, 8*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving Tag F0458 (room size waiver) is recommended.

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 02/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5293

March 23, 2015

Ms. Julie Pitsenbarger, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, Minnesota 55343

Please note, this letter has been re-issued with a correction to the tag cited for the room size waiver

Dear Ms. Pitsenbarger:

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 February 18, 2015 the above facility is certified for:

138 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 138 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Health Requirement: F0458 (Room Size Waiver). You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 20, 2015

Ms. Julie Pitsenbarger, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, Minnesota 55343

RE: Project Number S5293024

Dear Ms. Pitsenbarger:

On January 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 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 February 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 30, 2015 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 December 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2014, effective February 18, 2015 and therefore remedies outlined in our letter to you dated January 6, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiencyc cited under K0458 (Room Size Waiver) at the time of the December 19, 2014 standard extended 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.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245293	A. Building B. Wing	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **02/18/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/18/2015**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **02/18/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/18/2015**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **02/18/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/18/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **02/18/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/18/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/18/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/18/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/18/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	03/24/2015	32982	02/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2014			

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

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245293	01 - MAIN BUILDING 01	1/30/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	01/28/2015	ID Prefix Reg. # NFPA 101 LSC K0144	01/28/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	02/20/2015	28120	01/30/2015
CMS RO				

Followup to Survey Completed on: 12/17/2014

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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245293	A. Building 02 - 2008 ADDITION B. Wing	1/30/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	01/28/2015	ID Prefix Reg. # NFPA 101 LSC K0144	01/28/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	02/20/2015	28120	01/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
12/17/2014	

Protecting, Maintaining and Improving the Health of Minnesotans

February 20, 2015

Ms. Julie Pitsenbarger, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, Minnesota 55343

Re: Enclosed Reinspection Results - Project Number S5293024

Dear Ms. Pitsenbarger:

On February 18, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 19, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00872	A. Building B. Wing	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20550** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **02/18/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **02/18/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **02/18/2015**
ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **02/18/2015**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **02/18/2015**	ID Prefix **21385** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **02/18/2015**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **02/18/2015**	ID Prefix **21590** Reg. # **MN Rule 4658.1330** LSC	Correction Completed **02/18/2015**	ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **02/18/2015**
ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp.** LSC	Correction Completed **02/18/2015**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **02/18/2015**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/18/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	02/20/2015	32982	02/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 36LS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00872

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245293**
2.STATE VENDOR OR MEDICAID NO.
(L2) **417633200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2002**

6. DATE OF SURVEY **12/19/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving 0458 (room size waiver) is recommended.

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 01/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5483

January 6, 2015

Ms. Julie Pitsenbarger, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, Minnesota 55343

RE: Project Number S5293024

Dear Ms. Pitsenbarger:

On December 19, 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>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;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 January 28, 2015, 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 January 28, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 19, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R128, R124) was safe to self-administer medications. Findings include: R128's room was observed on 12/17/14, at 7:22 a.m. The door was wide open and the lights were off. R128 was lying on his back. - At 7:54 a.m. observed nursing assistant (NA)-C opened the bedside drawer and obtained pea size amount of Ketoconazole cream (used to treat a range of fungal skin infections) and applied the cream to the resident's back. When NA-C opened	F 176		

Received 1-20-15

RECEIVED
JAN 20 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 1/13/15

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

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F 176	Continued From page 1 the drawer there was medications that were observed to be stored in the drawer. - At 7:57 a.m. the observed medications in the drawer included Ketoconazole 1% shampoo, Ketoconazole cream 2%, Nystatin cream (used to treat fungal infections) 100,000 units, Albuterol inhaler (breathing medication) and budesonide inhaler (breathing medication). In addition, both inhalers were noted to have a different name on them which were not R128's. R128 was not able to converse at the time of observation. The Cognitive loss/dementia Care Area Assessment (CAAs) dated 9/17/14, identified R128 had Alzheimer's and dementia. R128 was also hard of hearing which could impact his cognition and cares. The CAA directed staff to continue to provide for his needs. The physician Order Summary Report dated 11/3/14, revealed the Ketoconazole shampoo and cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers. R128's Self-Medication Administration care plan dated 12/16/14, indicated the R128 would safely administer medications. The care plan directed staff to store medications in a secure location and there would be a periodic safety assessment/evaluation of R128's ability to administer medications. Assessment of Self-Administration of Medications dated 12/16/14, indicated R128 able to self-administer medications with setup by Nurse/trained medication aide (TMA) and nursing was responsible for storage and for documentation.	F 176	F 176 * All medications have been removed from the rooms of R128 and R124. Assessments have been completed for R128 and R124 pertaining to the safety in their ability to self administer medications. Self administration of medications will not occur for R128 and R124. * Medications will not be stored in resident rooms unless the resident has been assessed to be safe in the self administration of medications. Then those medications will be kept in safe storage in the resident's room. * All licensed nursing staff have been re-educated on the requirement that all residents must be properly assessed to self administer medications. If medications are to be self administered by the residents those medications need to be under safe storage in the resident's room. * Monitoring to ensure compliance will be conducted through random audits of resident rooms to ensure medications are not present in resident rooms unless the resident has been assessed to safely administer the medications and the medications are safely stored. * The facility QAPI committee will review the resident room medication audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 176	Continued From page 2 On 12/18/14, at 8:11 a.m. the director of nursing (DON) stated her expectation regarding storing medications to be self-administered in a resident's room stated, "The medications should not be in his room." R128 did not have an order for the inhalers and did not have an order to self-administer the inhalers. R128 was not administering their medications in a safe manner nor did the facility store the medications in a safe manner for R128 to self-administer. R124's room was observed on 12/15/14, at 4:00 p.m. and a bottle of Refresh eye drops (artificial tears for dry eyes) was on R124's bedside table. R124 claimed to own the bottle of eye drops and stated had to "use it three times a day" as recommended by "eye doctor." R124 further stated to have had the medication "all the time" at bedside table and instilled the eye drops to eyes by herself. -At 4:02 p.m. licensed practical nurse (LPN)-F came to R124's room and confirmed the presence of the eye drops on R124's bedside table. -At 4:04 p.m. LPN-F verified R124 did not have a doctor's medication order for the Refresh eye drops. LPN-F stated he would "take care of it." R124's care plan initiated on 11/29/11, indicated R124 as a resident of the nursing facility was receiving "care from someone else" and whose "safety is at risk." The care plan directed staff to remove R124 from potentially dangerous situations. The care plan also indicated R124 had impaired vision related to macular degeneration. The interventions section of the care plan was updated on 12/15/14, to add R124 can self-administer Refresh eye drops and bottle of eye drops to be kept at R124's bedside.	F 176		

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F 176	Continued From page 3 The Medication Administration Record (MAR) dated 12/01 through 12/31/14, indicated an update was entered on 12/15/14, reflecting the addition of the eye drops to R124's medication list. The MAR update read, "Refresh Tears Solution [Carboxymethylcelluslose Sodium] Instill 2 drops in both eyes three times a day for DRY EYES OK PER EYE DR TO SELF ADMINISTER AND KEEP AT BEDSIDE." On 12/19/14, at 8:52 a.m. the DON stated staff were expected to check medications that residents brought in to the facility, interview residents and discuss the medications; staff were to obtain proper orders for all medications; assess residents for safety in self-administration of medications; and ensure in safe keeping for medications. The facility Medication Administration-Preparation and General Guidelines Self-Administration of Medications policy dated 2006, (Revised November 2011) directed "in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." Procedures A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process." F. "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the	F 176		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 176	Continued From page 4 rooms of, or room with, residents who self-administer. Conditions outlined in 4.3: BEDSIDE MEDICATION STORAGE are met for bedside storage to occur."	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure dignified treatments were implemented for two residents (R165, R85) observed in the dining room and to one resident (R73) observed for medication administration through gastrostomy tube (g-tube). In addition, the facility failed to offer the residents a choice of condiments at meals. This had the potential to effect all 35 residents on the 2 west unit. Findings include: R165 On 12/17/14, at 8:45 a.m. R165 was observed at the 1 East dining room, seated in wheelchair and with two other residents at the dining table. Nursing assistant (NA)-D was seated in a chair on R165's left side and was feeding R165. There was no verbal cueing heard or any other form of communication observed between NA-D and R165, aside from the acts of NA-D giving spoons-full of food to R165. Surveyor was within range	F 241	F 241 * The resident, R165, will receive respectful and dignified care at all times. Staff will converse with R165 during meals and will explain cares and procedures to R165 before implementation. The resident, R85 will receive respectful and dignified care at all times. Staff will knock on room door before entering and will not allow R85 excessive wait time for meals and will explain cares and procedures to R85 before implementation. The resident, R73, will receive respectful and dignified care at all times. Staff will explain cares and procedures to R73 before implementation. The residents residing on the 2 West unit will have all the necessary condiments placed on the tables at each meal for consumption.	

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F 241	Continued From page 5 from R165's table enough to have heard any regular tone of conversation such as that from another resident at the same table, R125, who told NA-D about wanting to go back to room but NA-D did not say a word, nodded his head, and continued to feed R165. In addition, R165 was observed for at least three times having spilled food from mouth down to clothing protector, as was observed to only take small bites from the spoon full of food being fed by NA-D. For each time that food were being spilled from R165's mouth, NA-D used R165's clothing protector to wipe the corners of R165's mouth and chin. -At 8:55 a.m. NA-D stood up and continued to feed R165. NA-D was feeding R165 with thickened liquid contained in a plastic cup while he remained standing on R165's left side. The two plastic cups on R165's table were observed to be empty, while there were two bowls with about 75% of unfinished food in each. -At 8:58 a.m. NA-D wiped R165's mouth with the clothing protector, took the clothing protector off R165's neck, put it on the table, and then moved R165's wheelchair. NA-D never spoke to R165 before or while doing all these actions. -At 9:00 a.m. NA-D went on to push R165's wheelchair out from the dining room to the hallway and to R165's room. NA-D pushed R165 in wheelchair inside the room towards R165's bed; the room door was left open. NA-D positioned R165's wheelchair to face door, then locked the wheelchair brakes. NA-D placed call button on R165's lap then left the room, still without talking to R165. -At 9:04 a.m. R165 looked towards the door when surveyor knocked and signified to enter room. R165 was able to maintain eye contact when greeted. R165 nodded to agree when surveyor asked to verify that NA-D never talked all through	F 241	* All residents residing in the facility will receive respectful and dignified care at all times. Staff will knock on doors before entering resident rooms, staff will explain cares and procedures before commencing, and staff will converse with residents during cares. Residents will not have excessive wait times for meals. All dining areas in the facility will have the necessary condiments placed on the tables at each meal for consumption. * All nursing staff have been re-educated on the requirement that residents must receive respectful and dignified care at all times. Staff have been educated to knock on doors before entering, to explain cares and procedures before implementation, and to converse with residents during cares. Staff have been educated on the requirement that residents will not have excessive wait times for meals. All dietary staff have been educated on the requirement to have fully stocked condiment containers on all resident tables for all meals. * Monitoring to ensure compliance will be conducted through random resident care audits encompassing observation of dignified resident care. Dining room observational audits will also be conducted to ensure excessive wait time for meals is not present and condiment containers are in proper use at every meal.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 241	Continued From page 6 the time NA-D was with R165 from the dining room to R165's bedroom and until NA-D left the room. However, when surveyor re-phrased question to ask if NA-D talked or explained what he was doing, R165 just stared at surveyor then moved head to look at the television show on roommate's side. When asked if R165 felt ignored about NA-D's treatment, R165 kept quiet and kept eyes on the television. R165's current care plan, initiated on 12/23/13, indicated R165's safety was at risk in relation to medical conditions and clinical manifestations to include altered mental status and limited ability to communicate in English. The care plan directed staff to do the following interventions: explain all procedures and cares before performing them; provide reality orientation while giving care; use short phrases and questions which require yes or no answers and use gestures as needed; use verbal reminders which assist patient in orientation; explain what was going on in the environment; use communication book or pictures as needed to help with communication; and provide with interpreter as needed. The Care Area Assessments (CAA) dated 9/24/14, indicated R165 had problem with communication, and had limited English speaking ability, as would only able to understand some and communicate some. The CAA indicated staff to "use simple means of communication" to include gestures and communication book. The CAA also indicated R165 had problem with psychosocial well-being related to change in communication, and with the diagnoses of dementia and depression. The Diagnosis Information section of R165's	F 241	* The facility QAPI committee will review the dignity resident care audits and the dining room observational audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 241	Continued From page 7 electronic Admission Record revised 12/3/14, indicated R165 was enrolled for palliative care on 12/3/14. R165's Minimum Data Set (MDS) for significant change in status dated 12/10/14, indicated R165 did not speak words, and rarely had the ability to make self-understood nor to understand others. The MDS identified R165 to have long and short term memory loss. The MDS also indicated R165 was totally dependent on staff for all activities of daily living (ADL) to include transfers, mobility and locomotion. On 12/17/14, at 1:21 p.m. NA-D stated R165 understood English but "would take time." NA-D added R165 would nod if was in agreement with something. NA-D did not deny surveyor's observations that he did not give any explanations regarding his actions during the time he was with R165 in the dining room for breakfast until he took R165 back to room and until he left. NA-D did not deny that he was standing beside R165 while he continued to feed R165 with breakfast. R85 On 12/17/14, at 7:41 a.m. R85 room door was open. R85 was observed sitting in wheelchair beside bed, with eyes closed. The room was quiet. -At 7:44 a.m., a NA-A entered R85's room without knocking on door, approached R85, then without saying a word, started to unlock R85's wheelchair brakes. NA-A called R85's name once, touched R85's hand but R85's eyes remained closed. NA-A pushed R85's wheelchair from room to hallway then to the 2 East dining room, stopped	F 241		

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F 241	Continued From page 8 at a table, locked wheelchair brakes then left R85 without talking to R85. -At 7:52 a.m. R85 remained seated in wheelchair on the same spot where NA-A had parked the wheelchair. R85's eyes remained closed. R85 was alone at table. There were four other residents in the dining room but no staff was present. -At 8:07 a.m. a dietary staff was observed working in the mini-kitchen. R85's eyes were still closed. R85 was wearing a green clothing protector. -At 8:19 a.m. R85 had leaned head towards wheelchair's head rest, with eyes closed. No food was served at R85's table yet. -At 8:31 a.m. R85 was still seated on the same spot in the dining room, with eyes remained closed. -At 8:37 a.m. R85 still had eyes closed, alone at dining table. A glass of milk and a glass of orange juice were observed sitting on R85's table. -At 8:42 a.m. a NA-C finally went to serve breakfast plate to R85. NA-C was observed providing R85 with total assistance with feeding and was talking to R85 during the entire time. R85's electronic Admission Record dated 12/2/11, indicated R85 had urinary tract infection, Alzheimer's disease and vascular dementia. The care plan initiated on 12/6/11, indicated R85 had cognitive loss and diminished decision making capabilities and safety and security issues. The care plan directed staff to provide environmental cues to minimize cognitive deficits. The care plan also indicated R85 wanted to remain comfortable in the nursing home. The care plan further directed staff to introduce themselves when assisting with activities of daily	F 241		

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F 241	Continued From page 9 living and staff were to tell R85 what they were doing during cares and when assisting with meals. R73 On 12/18/14, at 7:26 a.m. licesned practical nurse (LPN)-E was observed for the process of medication administration through g-tube to R73. -R73 was lying in bed with the head of bed elevated about 10 to15 degrees. An ongoing tube feeding was observed, with a bottle that contained approximately 50 milliliters (ml) of feeding formula attached to R73 through g-tube. LPN-E did not correct nor made sure R73 was in the right position for tube feeding. LPN-E did not explain what he was going to do to R73. -Without saying a word to R73, LPN-E turned off the tube feeding then disconnected it from the g-tube connection site. -LPN-E administered the medications through R73's g-tube without talking to R73. LPN-E never paused to check how R73 felt. R73 was quiet during the whole medication administration procedure. R73's eyes followed what LPN-E was doing. -After the medications were administered via R73's g-tube, LPN-E re-connected the feeding tube and turned it on. LPN-E did not verbalize to R73 that he was done giving medication. LPN-E placed the call light on top of R73's abdomen, then stepped out of the room. R73's current care plan initiated on 4/3/13, indicated R73's safety was at risk and had potential for abuse related to decreased cognition, inability to communicate, need for total care and decreased physical ability. The care plan directed staff to explain actions before doing them; and to explain environment to help keep	F 241		

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F 241	Continued From page 10 R73 understand what was going on around. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated it was her expectation for staff to treat residents with dignity at all times. The facility's Social Services Policies and Procedures Manual, Section 7: Residents' Rights, Subject: SS-702 Dignity dated as revised on 10/09, indicated all residents will be treated with respect and dignity, so as to enhance each resident's self-worth and improve his/her psychosocial well-being and quality of life. The policy directed staff to speak to residents in a friendly and patient manner, and to focus on the resident as an individual when talking to them. In addition, the policy directed staff to respect residents' private space and property. On 12/16/14, at 8:30 a.m. at breakfast, there were no evidence of salt or pepper shakers on the tables, and there was no evidence of any salt or pepper packets having been used. There were also no sugar packets available on the tables. - At 8:35 a.m. NA-G and NA-H were interviewed and stated they were to ask if residents wanted salt or pepper. During the meal observation there was no observation of staff in the dining room asking residents if they wanted salt and/or pepper. The tables were void of empty packets on the tables. Residents were observed eating their eggs without salt or pepper. - At 8:45 a.m. Cook-A and the assistant director of nursing (ADON) explained, there were salt and pepper packets in the cupboard and the residents would need to ask for it. They went on to explain salt and pepper shakers were used in the past, but residents would sometimes pour too much on their food or unscrew the top, so they do not put	F 241		

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F 241	Continued From page 11 them out anymore. They verified that not all resident were able to request condiments. On 12/17/14, at 7:45 a.m. the cupboards in the dining room were observed and there large plastic bags of salt and pepper packets available for the staff to offer the residents. The residents were not afforded the choice of sugar, salt and/or pepper for the food that was served.	F 241		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure comprehensive re-assessments were completed for 1 of 3 residents (R126) reviewed for accidents. Findings include: On 12/15/14, at 8:07 p.m. R126's bed was observed to have a big gap between the edge of the mattress and the bed's foot board. The mattress was observed to be too short for the bed frame. On 12/16/14, at 11:25 a.m. surveyor asked maintenance director (Other)-B to measure the mattress against the bed frame. Other-B measured the gap between the mattress and the foot board to be 4.75 inches and the gap between	F 276	F 276 * Resident, R126, has had the mattress replaced on his bed. The new mattress does not allow any gaps between the mattress and the head and foot boards. R 126's environment has been assessed for any potential hazards and documented in the medical record. * All residents will have the environment assessed for potential hazards including the mattress as part of the documentation completed in the post fall scene investigative reports. All residents will have the environment assessed for potential hazards including the mattress as part of the quarterly resident review assessment in which the resident's risk for falls is evaluated. * Clinical Managers have been re-educated on the requirement to include	

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F 276	Continued From page 12 the mattress and the head board was 2.5 inches. Other-B confirmed R126's mattress was 7.25 inches shorter than the bed frame. Other-B then placed the gap-filler he was holding to fill the gap on R126's foot part. On 12/17/14, at 1:01 p.m. the gap-filler that was placed by Other-B in R126's bed was no longer in R126's bed. The mattress was held in place by what looked like a wire holder, that held the mattress in place. The gap between the mattress and the foot board was observable from the hallway as R126's room door was open during the days of survey. The electronic Admission Record dated 3/22/13, indicated R126 was admitted with diagnoses including dementia, uncontrolled diabetes, mild cognitive impairment and visual impairment related to diabetes. The electronic Admission Record also indicated R126 had been in the same room and bed since admission. The annual Minimum Data Set (MDS) dated 3/25/14, indicated R126 had no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicated R126 had a fall with no injury and the medical record lacked a comprehensive re-assessment of the fall and the use of the ill-fitting mattress. Despite the absence of a comprehensive fall re-assessment, a care plan was initiated on 3/25/13, to indicate R126 was at risk for falls due to medication use, diagnoses of dementia and polyneuropathy. The care plan described R126 to have decreased physical ability and increased cognitive impairment. The care plan further described R126 to have poor safety awareness	F 276	the environmental hazard assessment in the post fall scene investigative reports and the quarterly resident review assessment. * Monitoring to ensure compliance will be conducted through random audits of post fall scene investigation reports and quarterly resident review assessments to ensure the environmental hazard evaluation has been conducted and documented. * The facility QAPI committee will review the fall investigation audits and quarterly resident assessment audits for further recommendations. * The date of completion will be 1-28-15.	

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F 276	Continued From page 13 and impaired judgment. R126's mattress was not identified as a potential hazard that could contribute to events of a fall. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated staff were expected to comprehensively assess resident's needs, develop a care plan and follow the care plans for all residents.	F 276		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure care plan was followed for one of two residents reviewed (R165) reviewed for palliative care. In addition, the facility failed to ensure 1 of 2 residents (R128) care plan was followed for the safe storage of medication when R128 was identified to self-administer medications. Findings include: R165 was observed on 12/17/14, at 8:45 a.m. in the 1 East dining room, seated in wheelchair and with two other residents at the dining table. Nursing assistant (NA)-D was seated in a chair on R165's left side and was feeding R165. There was no verbal cueing heard or any other form of communication observed between NA-D and	F 282	F 282 * Resident, R165, will receive respectful and dignified care at all times. Staff will converse with R165 during meals and will explain cares and procedures to R165 before implementation as per plan of care. The resident, R128, will not have medications present in his room. Assessments have been completed for R128 pertaining to ability to self administer medications. Self administration of medications will not occur for R128. Care plan reflects R128's inability to self administer medications. * All residents residing in the facility will receive respectful and dignified care at all times. Staff will converse with residents during cares and will explain cares and procedures before implementation as per plan of care. Medications will not be stored in all resident rooms unless the resident has been assessed to be safe in the self administration of medications. Then those medications will be kept in safe storage in the resident's room as per the plan of care.	

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F 282	Continued From page 14 R165, aside from the acts of NA-D giving spoons-full of food to R165. Surveyor was within range from R165's table enough to have heard any regular tone of conversation such as that from another resident at the same table, R125, who told NA-D about wanting to go back to room but NA-D did not say a word, nodded his head, and continued to feed R165. In addition, for three times during the feeding observation, R165 could only take so much food from the spoon, so the rest of the food spilled over R165's mouth down to the clothing protector. NA-D used R165's clothing protector to wipe the corners of R165's mouth and chin each time food spilled. -At 8:55 a.m. NA-D stood up and continued to feed R165. NA-D was feeding R165 with thickened liquid contained in a plastic cup while he remained standing on R165's left side. The two plastic cups on R165's table were observed to be empty, while there were two bowls with about 75% of unfinished food in each. -At 8:58 a.m. NA-D wiped R165's mouth with the clothing protector, took the clothing protector off R165's neck, put it on the table, and then moved R165's wheelchair. NA-D never talked to R165 before or while doing all these actions. -At 9:00 a.m. NA-D went on to push R165's wheelchair out from the dining room to the hallway and to R165's room. NA-D pushed R165 in wheelchair inside the room towards R165's bed, the room door was left open. NA-D positioned R165's wheelchair to face door, then locked the wheelchair brakes. NA-D placed call button on R165's lap then left the room, still without talking to R165. -At 9:04 a.m. R165 looked towards the door when surveyor knocked and signified to enter room. R165 was able to maintain eye contact when greeted. R165 nodded when surveyor asked to	F 282	* All nursing staff have been re-educated on the requirement that residents must receive respectful and dignified care at all times. All licensed nursing staff have been re-educated on the requirement that all residents must be properly assessed to self administer medications. If medications are to be self administered by the residents those medications need to be under safe storage in the resident's room. * Monitoring to ensure compliance will be conducted through random resident care audits encompassing observation of dignified resident care as per the plan of care. Random audits of resident rooms will be conducted to ensure medications are not present in resident rooms unless the resident has been assessed to safely administer the medications and the medications are safely stored as per the plan of care. * The facility QAPI committee will review the resident room medication audits and the dignity resident care audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 282	Continued From page 15 verify that NA-D never talked all through the time NA-D was with R165 from the dining room to R165's bedroom and until NA-D left the room. However, when surveyor re-phrased question to ask if NA-D talked or explained what he was doing, R165 just stared at surveyor then moved head to look at the television show on roommate's side. The Diagnosis Information section of R165's electronic Admission Record indicated R165 was admitted on 12/20/13, with diagnoses including dizziness and giddiness, pneumonia, diabetes, dementia, depressive disorder, and paralysis agitans also known as Parkinson's disease (characterized by shaking of fingers and hands, muscle rigidity and shuffling gait). It was further indicated R165 was enrolled for palliative care on 12/3/14. The Care Area Assessments (CAA) dated 9/24/14, indicated R165 had problem with communication, and had limited English speaking ability, as would only able to understand some and communicate some. The CAA indicated staff to "use simple means of communication" to include gestures and communication book. The CAA also indicated R165 had problem with psychosocial well-being related to change in communication, and with the diagnoses of dementia and depression. R165's current care plan, initiated on 12/23/13, indicated R165's safety was at risk in relation to medical conditions and clinical manifestations to include altered mental status and limited ability to communicate in English. The care plan directed staff to do the following interventions: explain all procedures and cares before performing them;	F 282		

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F 282	Continued From page 16 provide reality orientation while giving care; use short phrases and questions which require yes or no answers and use gestures as needed; use verbal reminders which assist patient in orientation; explain what is going on in the environment; use communication book or pictures as needed to help with communication; and provide with interpreter as needed. On 12/17/14, at 1:12 p.m. NA-F stated R165 understood English but could not speak the language. NA-F stated R165 would nod if there was something R165 agreed with or wanted but R165 would shake head if did not want something. NA-F further described R165 as "a nice guy" and never called for help so staff would just have to go "check every two hours." -At 1:21 p.m. NA-D stated R165 understood English but "would take time." NA-D added R165 would nod if was in agreement with something. NA-D did not deny surveyor's observations that he did not give any explanations regarding his actions during the time he was with R165 in the dining room for breakfast until he took R165 back to room and until he left. NA-D did not deny that he did not give any environmental re-orientation to R165 during the time he was observed with R165. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated it was her expectation for staff to follow care plans of residents, for staff to talk to and explain procedures and cares to residents before doing them. The facility's Social Services Policies and Procedures Manual, Section 7: Residents' Rights, Subject: SS-702 Dignity dated as revised on 10/09, indicated all residents will be treated with	F 282		

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F 282	Continued From page 17 respect and dignity, so as to enhance each resident's self-worth and improve his/her psychosocial well-being and quality of life. The policy directed staff to speak to residents in a friendly and patient manner, and to focus on the resident as an individual when talking to them. R128's room was observed on 12/17/14, at 7:22 a.m. The door was wide open and the lights were off. R128 was lying on his back. - At 7:54 a.m. observed NA-C pull bedside drawer open and obtained pea size amount of Ketoconazole cream (used to treat a range of fungal skin infections) and applied the cream to the resident's back. When NA-C opened the drawer there were medications that were observed to be stored in the drawer. - At 7:57 a.m. the observed medications in the drawer included Ketoconazole 1% shampoo, Ketoconazole cream 2%, Nystatin cream (used to treat fungal infections) 100,000 units, Albuterol inhaler (breathing medication) and budesonide inhaler (breathing medication). Both inhalers were noted to have a different name on them which was not R128's. The Cognitive loss/dementia CAAs dated 9/17/14, identified R128 had Alzheimer's and dementia. R128 was also hard of hearing which could impact his cognition and cares. The CAA directed staff to continue to provide for his needs. The physician Order Summary Report dated 11/3/14, revealed the Ketoconazole shampoo and cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers. R128's Self-Medication Administration care plan dated 12/16/14, indicated the R128 would safely	F 282		

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F 282	Continued From page 18 administer medications. The care plan directed staff to store medications in a secure location and there would be a periodic safety assessment/evaluation of R128's ability to administer medications. Assessment of Self-Administration of Medications dated 12/16/14, indicated R128 able to self-administer medications with setup by Nurse/trained medication aide (TMA) and nursing was responsible for storage and for documentation. On 12/18/14, at 8:11 a.m. the DON stated her expectation regarding storing medications to be self-administered in a resident's room stated, "The medications should not be in his room." DON further acknowledged the care plan was not being followed. The facility Medication Administration-Preparation and General Guidelines Self-Administration of Medications policy dated 2006, (Revised November 2011) directed "in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." Procedures A. "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process." F. "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the	F 282		

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F 282	Continued From page 19 rooms of, or room with, residents who self-administer. Conditions outlined in 4.3: BEDSIDE MEDICATION STORAGE are met for bedside storage to occur."	F 282		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure universal precaution was observed for the care of gastrostomy tube (g-tube); and facility did not ensure gastric residual was checked and proper positioning was implemented during feeding and prior to medication administration via g-tube for 1	F 322	F 322 * The resident, R73, will receive proper cares associated with g-tube administration of nutrition and medication administration. G-tube cares will maintain proper explanation of cares, proper positioning, gastric residual checking, and adherence to proper flushing protocols and universal precautions. * All residents residing in the facility who require g-tube nutrition or medications will receive proper g-tube cares which will encompass proper explanation of cares, proper positioning, gastric residual checking, and adherence to proper flushing protocols and universal precautions. * All licensed nurses have been re-educated on the proper procedures to follow for administration of g-tube nutrition and medication administration. The re-education encompassed proper explanation of cares, proper positioning, gastric residual checking, and adherence to proper flushing protocols and universal precautions. * Monitoring to ensure compliance will be conducted through random observational audits of licensed nurses performing g-tube medication administration and g-tube feeding.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 20 of 1 resident (R73) observed for medication administration through g-tube. Findings include: On 12/18/14, at 7:26 a.m. a series of actions observed regarding the process of medication administration through g-tube, included the following: R73 was observed to be lying in bed with head of bed elevated about 10 to 15 degrees. An ongoing tube feeding was observed, with a bottle that contained approximately 50 milliliters (ml) of feeding formula attached to R73 through g-tube. Licensed practical nurse (LPN)-E did not correct nor made sure R73 was in the right position for tube feeding. LPN-E turned off the tube feeding then disconnected tube from the g-tube connection site. LPN-E did not pinch off or clamp the tube. LPN-E placed the open end of the g-tube on R73's undraped abdominal skin area and hanged the disconnected tube where the formula bottle was on the pole. LPN-E took syringe from bedside table, aspirated water from water bottle, but pushed water out and back to water container when he realized he had to check g-tube placement first. LPN-E took a small white towel from bedside table then picked up the open end of the g-tube from R73's abdominal area, draped the abdominal skin area with the towel, then connected the piston syringe to the g-tube. LPN-E again disconnected the piston syringe from the g-tube when he realized having to	F 322	* The facility QAPI committee will review the resident room medication audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 322	Continued From page 21 measure air first. LPN-E did not pinch off or clamp the g-tube. LPN-E measured about 15 ml of air then re-connected the syringe to the g-tube. LPN-E injected the air while listening on the gastric area with the use of his stethoscope. LPN-E did not pull back to check gastric residual. LPN-E disconnected the piston syringe again from the g-tube without pinching off the g-tube, placed the open end on the towel-draped abdominal area, then holding the syringe, he pulled the plunger out from the barrel, then re-connected syringe barrel to g-tube. The nurse manager, LPN-C entered the room while LPN-E was telling surveyor that he was to flush g-tube first with 30 ml of water. LPN-E picked up water bottle and was about to pour water in the syringe without pinching off or clamping the tube but was stopped by LPN-C who then coached LPN-E to pinch off the tube first and also to first measure 30 ml of water for flushing. LPN-C instructed LPN-E to wait while LPN-C went out to get a 30 ml medication cup which LPN-E then used to measure the water for flushing. After all the due medications were given, with water flushes in between and final 30 ml flush at the end, LPN-E re-connected the feeding tube and turned the feeding pump on. LPN-E did not talk to R73 during the entire procedure of medication administration, and to check how R73 was feeling. LPN-E did not tell R73 that he was done giving medication. LPN-E then placed call light on R73's abdominal area, told surveyor he was done, and stepped out from the room. The water bottle which still contained water that turned cloudy from the medications and the syringe used	F 322		

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F 322	Continued From page 22 for medication administration were left at R73's bedside table. The electronic Admission Record indicated dated 2/11/08, revealed R73 was admitted with diagnoses to include acute respiratory failure, bleeding of the gastrointestinal tract, intestinal infections, and cerebrovascular disease. R73's current care plan initiated on 10/8/10, indicated R73 was dependent on tube feeding related to dysphagia (difficulty swallowing). Facility staff were directed to implement interventions which included elevating head of bed at least 30 to 45 degrees during feeding and to apply slight pressure to tube feeding syringe with flushes and medication administration. On 12/19/14, at 8:30 a.m. LPN-C agreed that nurses should not be left alone to do procedures they were not trained to do as it would be unsafe practice for the residents. LPN-C stated nurses were expected to check g-tube placement, gastric residuals, elevate head of bed as tolerated by residents, and talk to residents to check if they were all right. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated nurses were expected to follow proper procedures in medication administration through the g-tube to include aseptic technique and placing a drape to protect the g-tube and not just leave the open end lying on top of resident's bare abdominal skin. DON also stated emphasis to staff about explaining procedures before performing them. The facility's policy for Administration of Enteral Feeding with last review dated 11/13/14, directed	F 322		

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F 322	Continued From page 23 staff to explain procedure to the resident; place the resident in a sitting or semi-sitting position, with the head of bed elevated at least 30 degrees during the feeding and for at least an hour after the feeding; check placement by injecting 10 to 15 ml of air then slowly draw back to check gastric contents; pinch off g-tube below the port so air does not enter the stomach, do not let syringe run empty or pinch off g-tube before it runs empty; rinse the syringe after use; and observe the resident for signs of discomfort.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate sized mattress were in place to prevent accidents and injuries for 9 of 122 residents in the facility (R126, R226, R150, R148, R136, R28, R87, R224, R72). In addition, two unoccupied rooms were identified in the facility room audit, for ill fitting mattresses (W113 and E262). Findings include: R126's bed was observed on 12/15/14, at 8:07 p.m. to have a big gap between the edge of the	F 323	F 323 * Appropriate sized mattresses are present for residents R126, R226, R150, R148, R136, R28, R87, R224, R72. Appropriate sized mattresses are also present in rooms W113, and E262. * All resident beds in the facility contain appropriate sized mattresses which do not allow for gaps between the mattress and the headboard or footboard of the bed. * All staff have been re-educated on bed safety and the seven entrapment zones which could potentially be present placing any resident at risk. Staff have been re-educated on the requirement to notify maintenance immediately if a mattress is not properly fitting a bed or an entrapment potential is present. * Monitoring to ensure compliance will be conducted through random bed safety audits to ensure proper sized	

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F 323	Continued From page 24 mattress and the bed's foot board. The mattress was observed to be too short for the bed frame. On 12/16/14, at 11:25 a.m. surveyor asked maintenance director (Other)-B to measure the mattress against the bed frame. Other-B measured the gap between the mattress and the foot board to be 4.75 inches and the gap between the mattress and the head board was 2.5 inches. Other-B confirmed that R126's mattress was 7.25 inches shorter than the bed frame. Other-B then placed the gap-filler he was holding to fill the gap on R126's foot part. On 12/17/14, at 1:01 p.m. the gap-filler that was placed by Other-B in R126's bed was no longer in R126's bed. The mattress was held in place by what looked like a wire holder. The gap between the mattress and the foot board was observable from the hallway as R126's room door was open during the days of survey. R126's current care plan initiated on 3/25/13, indicated R126's safety was at risk related to diagnosis of diabetes with neuropathy, retinopathy, and increased cognitive impairment. The care plan further described R126 to have poor safety awareness and impaired judgment. The care plan directed staff to remove R126 from potentially dangerous situations. R126 had diagnoses including dementia, uncontrolled diabetes, mild cognitive impairment and visual impairment related to diabetes. R226's care plan dated 12/5/14, indicated at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for	F 323	mattresses and the absence of entrapment zones. * The facility QAPI committee will review the bed safety audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 323	Continued From page 25 proper fit. The Care Area Assessment (CAA) dated 12/12/14, indicated risk of falls related to difficulty sequencing tasks, difficulty stabilizing when first standing and antipsychotropic medications. The Minimum Data Set (MDS) dated 12/8/14, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 (mild cognitive impairment), and required staff assistance for sequencing of daily activities. The facility bed audit it was noted the mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a "temporary" bolster was added for safety. On 12/18/14, at 10:36 a.m. the facility stated they did not have enough bolsters available and so purchased round flexible foam noodles (swim noodles), cut them into three pieces and "securely" taped the three pieces into a triangle shape and identified it as a "temporary bolster." On 12/18/14, at 3:00 p.m. the mattress was replaced. R150's MDS dated 11/6/14, indicated a BIMS score of 7/15 (severe cognitive impairment), was moderately depressed and rejected cares one to three days during the assessment period. R150 required extensive assist of two staff for bed mobility and toilet use, and limited assist of one staff for transfers, and supervision to walk in the room. The CAA dated 11/7/14, indicated R150 moves from a flat affect and isolating to smiling and socializing, and her daily needs vary. Staff assist with transfers and mobility to maintain safety. R150's care plan dated 11/27/14, identified at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit, R150 required	F 323		

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F 323	Continued From page 26 assistance with bed mobility as needed. During a facility bed audit it was noted that R150's mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a bolster was added for safety. R148's CAA dated 7/29/14, indicated R148 was at risk for falls related to balance, wandering and medication use. The care plan dated 8/4/14, indicated insomnia, sleep disturbances, and indicated at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The MDS dated 10/28/14, indicated a BIMS score of 14/15 (no cognitive impairment), was mildly depressed and did not reject cares or wander during the assessment period. R148 was independent in transfers and required cueing for toilet use. During a facility bed audit it was noted that R148's mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a bolster was added for safety R136's care plan dated 10/28/14, indicated at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper. The CAA dated 10/30/14, indicated a history of falls prior to admission and at risk of falls. R136 was re-admitted to the facility on 11/28/14, with admission diagnosis of depression, episodic mood disorder and generalized anxiety per the admission record. A discharge MDS dated 11/28/14, indicated a BIMS score of 13/15 (no cognitive impairment), was moderately	F 323		

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F 323	Continued From page 27 depressed, and had verbal behavioral symptoms daily, and rejected care one to three days during the assessment period. R136 required limited assistance in transfers, toilet use, bed mobility and used a four-wheeled rolling walker to ambulate on the unit and in her room. The medical record lacked evidence of an assessment of the mattress on the bed. During a facility bed audit it was noted that R136's mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a bolster was added for safety. R28's MDS dated 10/2/14, indicated short term and long term memory problems with fluctuating inattention and psychomotor retardation. R28 was severally depressed and did not reject cares or wander during the assessment period. R28 required two person limited assistance for bed mobility, one person limited assistance for toilet use and supervision for transfers and to walk in room. The care plan dated 11/22/14, indicated at risk for falls related to use of medication, impaired cognition, weakness and fatigue, and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The CAA dated 12/4/14, at risk for falls related to balance problems during transition and antipsychotic medications. During a facility bed audit it was noted that the mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a "temporary" bolster was added for safety. On 12/18/14, at 3:00 p.m. the mattress was replaced.	F 323		

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F 323	Continued From page 28 R87's annual MDS dated 9/9/14, indicated a BIMS of 10/15 (moderate cognitive impairment). R87 was mildly depressed and did not reject cares or wander during the assessment period. R87 required one person extensive assistance for bed mobility, toilet use, and transfers; and limited assistance of one staff to walk in room. The CAA dated 9/22/14, indicated at risk of falls related to dementia and psychiatric conditions. The care plan dated revised 12/14, indicated at risk of falls related to use of medication, dementia and Parkinson's disease, and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The incident/accident reports were reviewed and revealed the following: - On 1/16/14, at 10:00 a.m. R87 was found sitting on the floor next to her bed, stated she had been in bed and slid out. - On 4/19/14, at 5:41 a.m. R87 was found sitting on the floor beside the bed, stated she had slipped off the edge while trying to reach her shoes. - On 4/19/14, at 10:05 a.m. R87 was found on her knees next to the bed and stated the floor was slippery when she tried to get into bed. - On 10/5/14, at 2:00 p.m. R87 was found on the floor next to the bed, and stated she was sitting on the edge of the bed and reaching for something on the floor when she slid off the bed. R224 was admitted to the facility on 12/13/14, with admission diagnosis of sleep pattern disturbance and convulsions per the electronic Admission Record. A MDS was not available (recent admission). A care plan dated 12/14/14,	F 323		

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F 323	Continued From page 29 indicated R224 was at risk of falls related to use of medication and new environment; the care plan identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. During a facility bed audit it was noted that the mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a "temporary" bolster was added for safety. On 12/18/14, at 3:00 p.m. the mattress was replaced. R72's bed was observed on 12/16/14, at 12:53 p.m. with the Alzheimer's director (AD) and the assistant director of nursing (ADON). A five inch gap was measured at the end of the bed from the mattress to the foot board. The AD and the ADON had not been aware the mattress did not fit the bed. The ADON explained there was a system for staff to directly report to maintenance any problems with the beds or mattresses. She verified the mattress had not been reported. On 12/17/14, at 11:45 a.m. a bolster cushion was observed at the end of the mattress to fill the gap and prevent the mattress from moving. R72 had a significant change MDS completed on 4/22/14, and the subsequent CAA Summary indicated R72 was identified as being at risk for falls and that the facility would care plan the falls. However, the CAAs did not identify the the mattress as a potential fall risk. R72's quarterly MDS dated 7/22/14, identified R72 as having two falls with injury (since the last MDS) such as skin tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains; or	F 323		

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F 323	Continued From page 30 to have the resident complain of pain. R72's quarterly MDS dated 10/22/14, identified R72 as having two falls without injury and two falls with injury (since the last MDS) such as skin tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains; or to have the resident complain of pain. R72 was placed at risk for falls as the facility did not identify the ill-fitting mattress as a potential accident hazard. The care plan for R72, updated 10/22/14, indicated R72 was at risk for falls related to use of medication, new environment, history of falls, dementia, and chronic anxiety. The goal was for no falls or fall related injuries. Approaches included activity programming and exercises, assessment for pain ever shift, and asses the wheelchair for proper fit and safety. A lipped mattress with cut out was added as and intervention on 1/7/14. On 12/18/14, at 10:36 a.m. the director of nursing (DON) and director of environmental services (DES) were interviewed regarding potential patient entrapment issues, in the patent rooms where the mattresses did not fit the beds properly. When asked what rooms had improvised bolsters, and what rooms had bolsters added, the DON stated "I do not know off the top of my head." "We had some (bolsters) on hand, and had to make some temporary (bolsters) then had to order I think 10." The temporary bolsters were created when the facility went to the store and purchased foam swim noodles, cut them and "securely taped them together" then used as a bolster for five occupied beds. The DES stated the usual process when a mattress did not fit a bed properly was nursing would put a work order	F 323		

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F 323	Continued From page 31 into Engines (a facilities software program), then facilities would put in a bolster, or if a lip mattress was needed, facilities would change the mattress. The DON added Engines was set up in all computers and kiosks, so everyone can put in a work order. -The Safety Committee met once per month, and was facilitated by the administrator. -Room set up was an interdisciplinary process, the admissions director did the final check of the room for readiness. -There was a check list to ensure things were ready, but it did not include checking the mattress on the bed. -A list of the work order for mattress changes in Engines was requested from the DES (but not provided). On 12/18/14, at 2:45 p.m. a consultant with Health Care Services Group (housekeeping services) stated his staff would review mattresses for rips or un-cleanable surfaces which they report, but do not review to see if the mattress fit the bed properly. On 12/17/14, at 3:00 p.m. The Safety Committee Meeting minutes were reviewed for three months, and did not address the mattresses/beds in any way. On 12/17/14, at 3:30 p.m. the manufactures instructions for the bed say "a mattress at least 4 inches thick and of the recommended dimensions [the dimensions are not in the hand out]. Do not use without a special mattress designed to bend and conform to the shape of the bed." On 12/18/14, at 10:36 a.m. an interview with the DON and DES the facility did not have enough	F 323		

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F 323	Continued From page 32 bolsters available and so purchased round flexible foam noodles (swim noodles), cut them into three pieces and "securely" taped the three pieces into a triangle shape and identified it as a "temporary bolster." The DON and DES verified the facility had jerry-rigged a temporary bolster for three occupied beds, which had not been obtained from an approved manufacturer of health care products. On 12/18/14, at 12:30 p.m. The facility put together a 7 zones of entrapment education piece and educated everyone working in the facility currently, and will educate the evening shift when they arrive. On 12/18/14, at 3:00 p.m. all of the ill fitting mattresses (which included W113 and E262) were replaced with properly fitted mattresses obtained from storage, and from a sister facility. On 12/19/14, at 2:00 p.m. the DON stated in October of 2014, the facility had realized that the incident reports and fall huddle forms were not completed and provided re-education to the line staff on how to do the post fall huddle and document on the forms for more complete information for analysis of cause. "Our thoughts were we wanted to get more to the root cause to reduce the number of falls and eliminate repeat falls." The fall forms are reviewed in IDT (Interdisciplinary Team) meeting weekly. The Falls Management Guideline, dated 6/12/14, directed: *pre-admission intake assessment to assure appropriate fall interventions are in place prior to admission *new admission assessed for fall risk and	F 323		

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	245293	A. BUILDING _____ B. WING _____	12/19/2014

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F 323	Continued From page 33 immediate plan of care for falls initiated. *"fall alert" communication. *fall risk brochure provided to resident/family. *IDT team evaluates the fall prevention plan. *Complete Minimum Data Set and Care Area Assessments and care plan updated. *Following a fall, resident is assessed by licensed nurse and initiates the Change In Condition Report - Post Fall/Trauma, physician/representative notified. Appropriate interventions implemented, Care Plan updated. *Continue ongoing assessment QA Falls Intervention Tracking (a quality form), licensed nurse initiates DQI Quality Control Report, reported on 24 hour report, IDT team reviewed and makes additional recommendations within 72 hours. *QAPI (Quality Assurance Performance Improvement) committee minutes reflect data analysis..... to identify systemic trends and patterns.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	F 334 * The resident, R28, has been offered the pneumococcal vaccine and has received education regarding the benefits and potential side effects of the pneumococcal immunization. The medical record for R28 contains the verification that R28 received the immunization or did not receive due to medical contraindication or refusal. * All residents residing in the facility have been offered the pneumococcal vaccine and have received education regarding the benefits and potential side effects of the pneumococcal immunization. The medical record for all residents contains verification that the resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal. * All licensed nurses have been re-educated on the requirement to inform	

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F 334	Continued From page 34 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334	residents of the benefits and potential side effects of the pneumococcal vaccine and to record resident's immunization or decline of immunization on the form provided in the medical record. * Monitoring to ensure compliance will be conducted through random chart audits and audits of new admission charts to ensure proper documentation of immunization status is contained in the medical record. * The facility QAPI committee will review the immunization audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 334	Continued From page 35 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R28) was offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: The Order Summary Report dated December 1, 2014, indicated R28 was admitted to the facility on 11/21/14. Review of R28's immunization record lacked documentation if a pneumococcal vaccination had been received, contraindicated or refused. On 12/18/14, at 9:06 a.m. registered nurse (RN)-B, director of clinical education and infection control, verified R28 had not been given a consent on admission for pneumococcal vaccination. She further indicated she would have expected staff to provide consent and ask resident if she had received vaccination prior and the facility policy was to offer resident vaccination upon admission.	F 334		

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F 334	Continued From page 36 On 12/18/14, at 9:45 a.m. health unit coordinator (HUC) stated she had called the hospital where R28 had been discharged from and medical records had indicated there was no record of R28's pneumococcal immunization and the only one the hospital had was for influenza as noted on the discharge summary. Golden Clinical Services Infection Control policy and procedure manual dated 2007 (revised October 2011) indicated "Center will offer and encourage that each resident receive immunization against Influenza annually, as well as a lifetime immunization against Pneumococcal disease. This immunization will be administered unless it is medically contraindicated, the resident has already been immunized or the resident and/or responsible party refuses the immunization..."	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary food service environment. This had the potential	F 371	F 371 * The areas identified that required cleaning in the 1 East, 1 West, 2 East, and 2 West kitchenettes have all been cleaned. This cleaning has encompassed the microwave ovens, cupboards, drawers, and refrigerators located in these areas. The manual can	

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F 371	Continued From page 37 to affect all 122 residents in the facility. Findings include: A tour of the facility dining room serving kitchens was conducted on 12/17/14, at 2:30 p.m. with the food service director (FSD) and Registered dietitian (RD)-A. The following observations were made and verified by the FSD and RD-A: The 1 east serving kitchen microwave oven had a heavy build-up of debris on the interior top surface. The inside of two of four drawers contained considerable loose debris. The outside surfaces of the cupboards were soiled with spills and stains. The 1 west serving kitchen microwave oven was soiled on the interior surfaces. The refrigerator had a large spill of juice that had dried on and sticky. The FSD verified the oven and the refrigerator had not been kept up to standards. The 2 east serving kitchen cupboards were soled on the outer surfaces. Three of four cupboards had a build-up of crumbs and debris. The interior of the drawer located under the coffee maker was wet. There were packages of coffee in the drawer that were wet and there was loose coffee grounds throughout the drawer. The 2 West serving kitchen had two of six drawers with crumbs and debris. One of the drawers contained disposable forks loose in the drawer. On 12/15/14, at 12:02 p.m. with the FSD a manual can opener was observed with a heavy thick and sticky build-up covering the blade and face of the unit. The cogs of the gears had a build	F 371	opener in the kitchen has been replaced with a new can opener. * All kitchenette areas in the facility will be cleaned daily to ensure that the microwave ovens, cupboards, drawers, and refrigerators located in these areas are clean for food storage. The can opener in the kitchen will be checked and cleaned daily to prevent any contamination of food. * All dietary staff have been re-educated on the requirements for daily cleaning of the kitchenettes in the facility and the requirement for daily cleaning of the can opener located in the kitchen. * Monitoring to ensure compliance will be conducted through random audits of the facility kitchenettes for cleanliness. The audits will encompass checking the microwave ovens, cupboards, drawers, and refrigerators for proper cleanliness. Random audits will also be completed to ensure daily cleaning and sanitation of the can opener in the kitchen is maintained. * The facility QAPI committee will review the results of the kitchenette and kitchen sanitation audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 371	Continued From page 38 up of metal shaving. The FSD said he would expect the can opener to be cleaned daily and verified it was not in a sanitary condition. A weekly equipment cleaning schedule provided by the FSD and dated 12/14/14, lacked the inclusion of cleaning the can opener. A sanitation policy dated 2011, indicated it was the policy of the dining services department to practice proper sanitation techniques for clean equipment to prevent the outbreak of foodborne illness.	F 371	F 431 * The medications identified in the 2 East North medication cart which were expired or not properly dated when opened have been removed from the cart. The medication cart has been thoroughly cleaned. The medications identified in the 2 West medication cart which were expired or lacked the expiration date have been removed from the cart. The medication cart has been thoroughly cleaned. The medications from the 2 West medication room which lacked proper expiration dates or were expired have been removed and properly disposed of. The used fentanyl patches for R56 are being disposed and documented per policy with two licensed nurses signing and witnessing destruction via sewer. All medications have been removed from the room of R128. * All medication carts in the facility will be checked and will not contain expired medications, or medications not properly dated when opened. All medications will have expiration dates. All medication rooms in the facility will be checked and expired medications will be removed and disposed of properly. All used narcotic medication patches will be properly disposed per	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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F 431	Continued From page 39 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure expired medications were discarded; medication carts were kept clean. This had the potential to affect 60 out of 120 residents. In addition, the facility did not have a system to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 1 of 1 resident (R56). In addition, the facility failed to ensure 1 of 2 residents (R128) medications were stored safely who was identified as being able to self-administer their own medications. Findings include: 2 East Unit/ North-side Medication Cart On 12/18/14, at 11:18 a.m. during inspection of the 2 East medication cart, where the following ready to use medication were observed: A half-full bottle of facility supply Tums (medication for hyperacidity) which was expired on 9/10/14; an opened bottle of Levemir insulin and an opened bottle of Novolog insulin for R81 which had no labels as to when they were opened. The 2nd drawer was with thick, pink and white	F 431	policy with two licensed nurses signing and witnessing destruction via sewer. Medications will not be stored in all resident rooms unless the resident has been assessed to be safe in the self administration of medications. Then those medications will be kept in safe storage in the resident's room. * All licensed nurses have been re-educated on the requirements to remove expired medications from use, and to properly date medications when opened. The licensed nurses have also been re-educated on the requirement to keep the medication carts clean and to adhere to the cleaning schedules for the medication carts. The licensed nurses have also been re-educated on the protocols to follow for proper disposal of used narcotic patches and the requirement for two nurses to sign off destruction via sewer in the narcotic log book. All licensed nursing staff have been re-educated on the requirement that all residents must be properly assessed to self administer medications. If medications are to be self administered by the residents those medications need to be under safe storage in the resident's room. * Monitoring to ensure compliance will be conducted through weekly audits of medication carts and medication rooms to monitor for proper dating, storage, expiration of medications and sanitation of	

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F 431	Continued From page 40 powder build up at the back. The drawer contained 17 packages of pills. In addition, the 3rd and 5th drawers of the medication cart were observed to have thick, white powder build-up on the back and sides with multiple pieces of foil and approximately 30 bubble packages of pills. On 12/18/14, at 11:36 a.m. licensed practical nurse (LPN)-E verified the presence of expired medications and medications with no dates to indicate when they were opened. LPN-E also stated nurses were supposed to clean medication carts at the end of every shift and night nurses were charged to make sure medication carts were kept clean. 2 West Unit/ West-side Medication Cart On 12/19/14, at 9:39 a.m. LPN-G agreed to check the medication cart with surveyor, where the following ready to use medication were observed: a bottle of facility supply Naproxen (pain reliever and anti-inflammatory medication) 220 milligrams (mg) which was expired on 8/14; A bottle of mineral oil with no name written and also had no expiration date; R101's Trixaicin cream (pain reliever cream) and a Silverstat antibacterial wound dressing ointment had no expiration dates; and R118's Atropine sulfate (used to dilate the eye and reduces eye discomfort) 1% solution which was expired on 11/14. The middle drawer of the medication cart was also observed to be dirty with white powdery substances. A medication/treatment bin placed in the 4th drawer of the medication cart was dirty with thick, cream-colored and greasy substance. The 4th drawer also had white powders at the back and there were four white loose pills on the drawer floor. LPN-G stated nurses were	F 431	medication carts. Random audits will be conducted of resident rooms to ensure medications are not present in resident rooms unless the resident has been assessed to safely administer the medications and the medications are safely stored. * The facility QAPI committee will review the medication cart/med room audits and the resident room medication audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 431	Continued From page 41 responsible in cleaning carts and making sure medications were current. LPN-G agreed the medication cart drawers were dirty and stated she clean them. 2 West Unit Medication Room On 12/19/14, at 10:04 a.m. the 2 West Medication Room was checked with LPN-H. The following ready to use medication were observed: an open bottle of house stock of Vitamin D-400 international units (IU) with no expiration date; R141's unopened bottle of liquid Ativan (anti-anxiety medication) 2mg/ml which was expired on 8/14; LPN-H placed the liquid Ativan back to narcotic box, locked the box and put it back in the refrigerator. LPN-H stated she had to put the expired medication back in the locked box because two nurses were needed to discard it. On 12/18/14, at 11:21 a.m. the director of nursing (DON) stated nurses were expected to clean the carts. The DON added the facility's policy was not to have expired and undated medications in the medication carts and rooms. Fentanyl patches disposal 1 East Floor: On 12/19/14, at approximately 9:22 a.m. a tour of the medication cart was completed with LPN-B. During the tour inside the narcotic box to the back was observed an opened box of Fentanyl patches for R56. When asked what the facility policy was for disposing used patches LPN-B stated she was not sure and would get back to surveyor after asking her supervisor. Upon reviewing the narcotic book it was revealed from 11/3/14, to 12/15/14, R56 had received the Fentanyl patch fourteen times of which only three times two nurses had documented witnessing the destruction.	F 431		

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F 431	Continued From page 42 -At 9:25 a.m. LPN-B approached surveyor stated two nurses were supposed to witness removing the used patch, flush it in the toilet and were both to document in the narcotic book the destruction. -At 9:27 a.m. RN-E also the unit nurse manager verified the nurses were not documenting witnessing the destruction which increased the potential for diversion. RN-E further stated it was facility policy both nurses to document in the narcotic book each time. On 11/6/14, at 1:42 p.m. DON stated it was the facility policy for both nurses to document immediately in the narcotic book upon completing the destruction. R56's Physician's Orders dated 11/5/14, indicated R56 had an order for the Fentanyl patch 72 hour 75 microgram (mcg)/hour (patch used for pain). R56's diagnoses included mylagia and myositis, hip joint replacement and aftercare for healing traumatic fracture of hip obtained from Admission Record dated 12/12/14. During review of R56's Electronic Medication Administration Record (EMAR) dated 12/1/14 through 12/18/14, it was revealed R56 had the Fentanyl patch removed and disposed of six times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for the removal, destruction and applying of the Fentanyl patch. Controlled Substance Disposal policy dated 5/12, directed "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of |two licensed	F 431		

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F 431	Continued From page 43 nurses|, and the disposal is documented on the accountability record/book on the line representing that dose ..." The policy did not indicate who was responsible to oversee the narcotic books were audited regularly to ensure nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion. R128's room was observed on 12/17/14, at 7:22 a.m. The door was wide open and the lights were off. R128 was lying on his back. - At 7:54 a.m. observed nursing assistant (NA)-C pull bedside drawer open and obtained pea size amount of Ketoconazole cream (used to treat a range of fungal skin infections) and applied the cream to the resident's back. When NA-C opened the drawer there were medications that were observed to be stored in the drawer. - At 7:57 a.m. the observed medications in the drawer included Ketoconazole 1% shampoo, Ketoconazole cream 2%, Nystatin cream (used to treat fungal infections) 100,000 units, Albuterol inhaler (breathing medication) and budesonide inhaler (breathing medication). Both inhalers were noted to have a different name on them which was not R128's. R128 was unable to converse at the time of the observation. The Cognitive loss/dementia Care Area Assessment (CAAs) dated 9/17/14, identified R128 had Alzheimer's and dementia. R128 was also hard of hearing which could impact his cognition and cares. The CAA directed staff to continue to provide for his needs. The physician Order Summary Report dated 11/3/14, revealed the Ketoconazole shampoo and cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers.	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 44 R128's Self-Medication Administration care plan dated 12/16/14, indicated the R128 would safely administer medications. The care plan directed staff to store medications in a secure location and there would be a periodic safety assessment/evaluation of R128's ability to administer medications. Assessment of Self-Administration of Medications dated 12/16/14, indicated R128 able to self-administer medications with setup by Nurse/TMA and nursing was responsible for storage and for documentation. On 12/17/14, at 8:20 a.m. LPN-A was asked if R128 could self-administer medications. RN-A stated, "He cannot administer medications himself." On 12/18/14, at 8:11 a.m. the DON stated her expectation regarding storing medications to be self-administered in a resident's room stated, "The medications should not be in his room." The facility Medication Administration-Preparation and General Guidelines Self-Administration of Medications policy dated 2006, (Revised November 2011) directed "in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." Procedures A. "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including	F 431		

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	245293	A. BUILDING _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 45 orientation to time), physical, and visual ability to carry out this responsibility during the care planning process." F. "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. Conditions outlined in 4.3: BEDSIDE MEDICATION STORAGE are met for bedside storage to occur."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F 441 * The resident, R89, will be provided cares in which the nursing staff will adhere to correct hand washing and changing of soiled gloves when gloves become contaminated during the provision of cares. * All residents residing in the facility will be provided cares in which the nursing staff will adhere to correct hand washing and changing of soiled gloves when gloves become contaminated during the provision of cares. * All nursing staff have been re-educated on the requirement to properly	

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F 441	Continued From page 46 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure handwashing was performed and gloves were changed after touching soiled items during the provision of cares to 1 of 3 residents (R89) reviewed for incontinence. Findings include: On 12/17/14, at 8:42 a.m. to 9:15 a.m. observed R89 in the dining room (DR) eating her breakfast with assistance. -At 9:16 a.m. observed nursing assistant (NA)-A wheeling R89 out of the DR into her room and stationed R89's wheelchair at her bedside door observed slightly open pulled the curtain and left the room briefly and shut the door. -At 9:19 a.m. observed NA-A going to room opened the door went to R89's side of room pulled the curtain then moved R89 closer to the bed and set the call light on R89's lap and left the room. -At 9:22 a.m. NA-A was observed going back to room then left the room briefly with a clear plastic bag with trash and went into the soiled utility room.	F 441	wash hands prior to the initiation of cares, to apply gloves, to remove gloves when gloves become contaminated during cares, to wash hands again before applying clean gloves, to remove gloves and wash hands before exiting the resident care area. * Monitoring to ensure compliance will be conducted through random care audits to ensure proper hand washing and application of clean gloves during cares is accomplished. * The facility QAPI committee will review the resident care audits for infection control quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 441	Continued From page 47 -At 9:38 a.m. observed NA-A going to room with the Hoyer lift (machine used for transferring) and shut the door upon entering NA-A indicated he was going to lay R89 down. -At 9:40 a.m. NA-A left the room stated he was going to find another staff to assist him to lay R89 down. -At 9:45 a.m. NA-A returned to room applied the lifting sheet on R89. -At 9:50 a.m. NA-B came to room. Both hooked the lift sheet to the Hoyer then communicated as they both assisted R89 off the wheelchair to her bed. -At 9:52 a.m. both cued R89 to turn her pulled the pants down removed the lift sheet. -At 9:54 a.m. to 10:00 a.m. NA-A was observed undo R89's incontinent pad stated R89 was not incontinent then proceeded to provide pericare to the front then as both NA's were turning R89 to the wall R89 started to urinate and was observed to have stool coming out. NA-B cued NA-A to change his gloves after completing the front pericare. NA-A was observed remove his gloves and donned two pairs of gloves without washing his hands then continued to complete pericare to the bottom wiped R89 removed the bowel movement never removed gloves applied a clean incontinent pad and touched R89 clothing, bedding that was on the way and R89 exposed lower extremities with the soiled gloves turned her to the door and fastened the incontinent pad then went over to the trash can pulled the plastic bag with soiled linen and incontinent products then removed the gloves never washed hands at this time still. -At 10:01 a.m. NA-A was observed leaving R89's room went to the soiled utility room when asked as he entered the room if he was supposed to wash his hands between glove changing and	F 441		

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F 441	Continued From page 48 after finishing to do provide pericare he stated he was supposed to wash and change gloves. NA-A acknowledged he had not changed his gloves after wiping resident bottom after cleaning the bowel movement. -At 10:04 a.m. licensed practical nurse (LPN)-A indicated NA-A was supposed to have changed his gloves after pericare and was also supposed to wash his hands between removing gloves "That is an infection control issue." On 12/18/14, at 1:31 p.m. When asked what her expectation on gloving, hand washing was registered nurse (RN)-B who also was in charge of the facility infection control program stated "staff have been taught when gloves are dirty they must take gloves off, wash their hands and reapply new gloves." Handwashing/Hand Hygiene policy revised August 2012, directed "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial soap and water under the following conditions: n. Before and after assisting a resident with toileting (hand washing with soup and water)..."	F 441		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not provide 80 square feet per resident for	F 458	Waiver Request * Golden Living Center Hopkins would like to request a waiver under F458 in regards to resident room size. The specific rooms to be included in this waiver are: 140, 141, 142, 143, 144, 146, 163, 165, 167, 169, 171, 173, 175, 222, 224, 240, 258, 260, 262, 264, 269, 271, and 277. * These rooms were constructed in 1955 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility. * Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The resident's health, treatments, comfort, safety, and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. * The Executive Director is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	

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F 458	Continued From page 49 rooms 141, 142, 143, 144, 146, 165, 171, 240, 258, 260, 264, 269, 271, and 277. Findings include: During the survey cares were observed in six of the 14 rooms with no concerns were noted in the delivery of care. During the survey from 12/15/14 through 12/19/14, neither the residents nor the families had concerns or complaints related to room size. During the enterance conference on 12/15/14, at 12 noon the adminsitrator stated in the past year, eight double rooms have been converted to private rooms.	F 458		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R102) room was kept clean and free of odors reviewed for environmental concerns. Findings include: R102's diagnoses dementia, hemiplegia, depression, seizure disorder and chronic pain obtained from the quarterly Minimum Data Set (MDS) dated 10/9/14. In addition, the MDS indicated R102 had both short and long term memory problems, required total dependence of	F 465	F 465 * Resident, R102's, room will be kept clean and free from odor. * All resident rooms will be clean and free from odor. All resident rooms will be cleaned and sanitized daily and more frequently if the need arises. * All staff have been re-educated on the requirement to notify housekeeping and/or facility management if an issue arises surrounding the cleanliness or odors present in resident rooms or any other resident care areas in the facility. * Monitoring to ensure compliance will be conducted through random environmental audits encompassing room cleanliness and presence of odors in resident rooms or resident care areas. * The facility QAPI committee will review the environmental audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

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F 465	Continued From page 50 one staff with toilet use and all other activities of daily living and had an indwelling catheter. On 12/15/14, at 4:50 p.m. as surveyor was walking down the hallway during the initial facility tour a strong musty malodorous smell was noted outside R102's room. Looking inside the room observed R102 lying in bed and the smell faded off from the hallway when registered nurse (RN)-A entered the room and shut the door. -At 4:52 p.m. the maintenance director stated he was not able to smell as he had been on the floor for a while and would come back maybe he would be able to pick the smell up. -At 4:56 p.m. housekeeping account manager approached surveyor indicated she wanted to go into R102's room but at the time R102's wife was visiting and was assisting R102. On 12/15/14, at 5:43 p.m. housekeeping account manager indicated the smell was urine smell and she was not sure where it was coming from after going into the bathroom and started to clean the room. -At 5:44 p.m. observed housekeeping account manager on her knees spraying the floor as she wiped all under and around the bed. -At 5:49 p.m. when asked if he had noticed the strong musty smell in the room when administering R102's medications RN-A indicated it was urine smell and further stated R102 had a suprapubic catheter and was at times incontinent and thought that was why there was urine odor in the room. On 12/15/14, at 7:20 p.m. housekeeping account manager stated "The smell was a lot better." When asked if she would have expected staff to let her department know about the smell she	F 465		

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F 465	Continued From page 51 stated "Yes" she further stated as she pointed to the air vent on the wall by the bathroom that when she had sprayed cleaning solution she had noticed a smell coming out of it and had thought that was where the smell was going from. On 12/16/14, at 9:10 a.m. to 3:00 p.m. room remained to have a strong urine smell. Several staff, residents and family members were observed going past the room to other rooms located down the hallway back and forth. No staff acknowledged R102's room needed to be cleaned. On 12/17/14, at 7:30 a.m. to 9:22 a.m. R102's room noted still to have a strong urine smell that was noticeable from standing or walking past the room in the hallway. R102's door was wide open at the time and several staff going by the room including the director of nursing (DON), maintenance director and the executive administrator. -At 9:22 a.m. surveyor and licensed practical nurse (LPN)-A went to room when asked what and where the smell was coming from LPN-A stated R102 had a catheter bag and thought that was where the smell was coming from and indicated he would change the catheter bag to see if the strong urine smell would fade off. -At 9:30 a.m. both maintenance director and housekeeping account manager approached the room both acknowledged the smell was urine and when maintenance director was asked to enter the room he stated he was able to smell the urine smell from standing outside the room in the hallway. Maintenance director further stated "Let us figure this out we are thinking it's the mattress" he turned to the housekeeping account manager and asked what time she wanted housekeeping	F 465		

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F 465	Continued From page 52 to coordinate with nursing to get R102 up for the room to be deep cleaned. On 12/18/14, at 8:16 a.m. the DON stated she and the executive director had identified the urine smell on 12/17/14, but was not sure of the time and had started to coordinate for R102's room to be cleaned. When asked if she expected staff to have reported the smell to housekeeping as soon as it was notice DON stated "Of course." On 12/19/14, the housekeeping policy was requested but was not provided instead in-service content was provided.	F 465		

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	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/17/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden LivingCenter Hopkins was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	Pick JR. 1-23-15 RECEIVED JAN 16 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 12-19-14 DO: 1-24-15

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

TITLE: Executive Director

(X6) DATE: 1/13/15

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

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Hopkins was constructed as follows: The original building was built in 1958, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 1st Addition was built in 1960, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 2nd Addition was built in 1965, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 3rd Addition was built in 1989, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 4th Addition was built in 1993, is two-stories, has no basement is fully fire sprinkler protected and is of Type II(222) construction; The most recent addition was constructed in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(222) construction.	K 000		

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K 000	Continued From page 2 The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. Because the original building and the five (5) additions meet the construction type allowed for both new and existing health care occupancies, the facility was surveyed as 1-building and two (2) Form CMS-2786R booklets were completed; Building 01 in accordance with Chapter 19 Existing Health Care Occupancies and Building 02 in accordance with Chapter 18 New Health Care Occupancies. The facility has a capacity of 133 beds and had a census of 119 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 12:45 PM	K 062	K 62 * A fire sprinkler flow test will be conducted on 1-14-15. * The fire sprinkler flow tests will be conducted on a quarterly basis beginning from January 2015 and going forward. * The maintenance staff have been trained on the regulation requiring quarterly fire sprinkler flow tests and the documentation of the quarterly fire sprinkler flow tests. * Monitoring to ensure compliance will be conducted by the Maintenance Director or designee through audits to ensure quarterly fire sprinkler flow tests are completed and documented. * The facility QAPI committee will review the maintenance audits quarterly for further recommendations. * The date of completion will be 1-28-15.	1-28-15

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

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K 062	Continued From page 3 on 12/17/2014, record review revealed that the last documented quarterly fire sprinkler flow was conducted on 05/15/2014. This deficient practice was verified by the maintenance supervisor at the time of the inspection.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 12:45 PM on 12/17/2014, record review revealed that the facility has not conducted annual load bank tests on their diesel generator. Monthly documentation reveals that the generator is testing at 25%. This deficient practice was verified by the	K 144	K 144 * A load bank test of the facility's generator will be conducted on 1-21-15 with the load bank supplemented to 30% or greater. * Monthly load bank tests of the facility generator will continue to be conducted monthly with the load bank being recorded. If monthly load bank tests are below 30% annual load bank supplementation tests will be conducted annually going forward. The annual load bank tests will require supplementation of the load to 30% to meet the requirement. * The maintenance staff have been trained on the requirement to have and record monthly load bank tests of the facility generator. The maintenance staff have been trained that if monthly load bank tests are less than 30% annual load bank supplementation tests must be conducted with the load being at 30% or greater. * Monitoring to ensure compliance will be conducted through maintenance audits checking on monthly completion of load bank tests with recorded results. * The facility QAPI committee will review the maintenance audits quarterly for further recommendations.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/17/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 maintenance supervisor at the time of the inspection.	K 144	* The date of completion will be 1-28-15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden LivingCenter Hopkins building 2 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

POC ok
1-23-15

RECEIVED
JAN 23 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	1-23-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Hopkins Therapy building 2 was constructed in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. Because the original building and the five (5) additions meet the construction type allowed for both new and existing health care occupancies, the facility was surveyed as 1-building and two (2) Form CMS-2786R booklets were completed; Building 01 in accordance with Chapter 19 Existing Health Care Occupancies and Building 02 in accordance with Chapter 18 New Health Care Occupancies. The facility has a capacity of 133 beds and had a census of 119 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(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 ACT ON SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2	K 062		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 12:45 PM on 12/17/2014, record review revealed that the last documented quarterly fire sprinkler flow was conducted on 05/15/2014. This deficient practice was verified by the maintenance supervisor at the time of the inspection.	K 062	K 62 * A fire sprinkler flow test will be conducted on 1-14-15. * The fire sprinkler flow tests will be conducted on a quarterly basis beginning from January 2015 and going forward. * The maintenance staff have been trained on the regulation requiring quarterly fire sprinkler flow tests and the documentation of the quarterly fire sprinkler flow tests. * Monitoring to ensure compliance will be conducted by the Maintenance Director or designee through audits to ensure quarterly fire sprinkler flow tests are completed and documented. * The facility QAPI committee will review the maintenance audits quarterly for further recommendations. * The date of completion will be 1-28-15.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 12:45 PM on 12/17/2014, record review revealed that the facility has not conducted annual load bank tests on their diesel generator. Monthly documentation reveals that the generator is testing at 25%. This deficient practice was verified by the maintenance supervisor at the time of the inspection.	K 144	K 144 * A load bank test of the facility's generator will be conducted on 1-21-15 with the load bank supplemented to 30% or greater. * Monthly load bank tests of the facility generator will continue to be conducted monthly with the load bank being recorded. If monthly load bank tests are below 30% annual load bank supplementation tests will be conducted annually going forward. The annual load bank tests will require supplementation of the load to 30% to meet the requirement. * The maintenance staff have been trained on the requirement to have and record monthly load bank tests of the facility generator. The maintenance staff have been trained that if monthly load bank tests are less than 30% annual load bank supplementation tests must be conducted with the load being at 30% or greater. * Monitoring to ensure compliance will be conducted through maintenance audits checking on monthly completion of load bank tests with recorded results. * The facility QAPI committee will review the maintenance audits quarterly for further recommendations. * The date of completion will be 1-28-15.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5483

January 6, 2015

Ms. Julie Pitsenbarger, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, Minnesota 55343

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5293024

Dear Ms. Pitsenbarger:

The above facility was surveyed on December 15, 2014 through December 19, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 15-19, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	1-13-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 15-19, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 these orders for your records and return the original to the address below: Gloria Derfus MDH, Division of Health Regulation LTC section PO Box 64900 St Paul, MN 55164-0900	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure comprehensive	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 550	Continued From page 2 re-assessments were completed for 1 of 3 residents (R126) reviewed for accidents. Findings include: On 12/15/14, at 8:07 p.m. R126's bed was observed to have a big gap between the edge of the mattress and the bed's foot board. The mattress was observed to be too short for the bed frame. On 12/16/14, at 11:25 a.m. surveyor asked maintenance director (Other)-B to measure the mattress against the bed frame. Other-B measured the gap between the mattress and the foot board to be 4.75 inches and the gap between the mattress and the head board was 2.5 inches. Other-B confirmed R126's mattress was 7.25 inches shorter than the bed frame. Other-B then placed the gap-filler he was holding to fill the gap on R126's foot part. On 12/17/14, at 1:01 p.m. the gap-filler that was placed by Other-B in R126's bed was no longer in R126's bed. The mattress was held in place by what looked like a wire holder, that held the mattress in place. The gap between the mattress and the foot board was observable from the hallway as R126's room door was open during the days of survey. The electronic Admission Record indicated R126 was admitted on 3/22/13, with diagnoses including dementia, uncontrolled diabetes, mild cognitive impairment and visual impairment related to diabetes. The electronic Admission Record also indicated R126 had been in the same room and bed since admission. The annual Minimum Data Set (MDS) dated	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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2 550	Continued From page 3 3/25/14, indicated R126 had no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicated R126 had a fall with no injury and the medical lacked a comprehensive re-assessment of the fall. However, R126 was not comprehensively re-assessed to include the fall occurrence and the use of the ill-fitting mattress. Despite the absence of a comprehensive fall re-assessment, a care plan was initiated on 3/25/13, to indicate R126 was at risk for falls due to medication use, diagnoses of dementia and polyneuropathy. The care plan described R126 to have decreased physical ability and increased cognitive impairment. The care plan further described R126 to have poor safety awareness and impaired judgment. R126's mattress was not identified as a potential hazard that could contribute to events of a fall. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated staff were expected to comprehensively assess resident's needs, develop a care plan and follow the care plans for all residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedure to determine and assess a residents change with fall risks. The Director of Nursing or her designee could educate the appropriate staff on the policy. The Director of Nursing or her designee could develop a system for monitoring for reassessment of resident fall risk function when a decline has been noted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure care plan was followed for one of two residents reviewed (R165) reviewed for palliative care. In addition, the facility failed to ensure 1 of 2 residents (R128) care plan was followed for the safe storage of medication when R128 was identified to self-administer medications. Findings include: R165 was observed on 12/17/14, at 8:45 a.m. in the 1 East dining room, seated in wheelchair and with two other residents at the dining table. Nursing assistant (NA)-D was seated in a chair on R165's left side and was feeding R165. There was no verbal cueing heard or any other form of communication observed between NA-D and R165, aside from the acts of NA-D giving spoons-full of food to R165. Surveyor was within range from R165's table enough to have heard any regular tone of conversation such as that from another resident at the same table, R125, who told NA-D about wanting to go back to room but NA-D did not say a word, nodded his head, and continued to feed R165. In addition, for three times during the feeding observation, R165 could only take so much food from the spoon, so the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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2 565	Continued From page 5 rest of the food spilled over R165's mouth down to the clothing protector. NA-D used R165's clothing protector to wipe the corners of R165's mouth and chin each time food spilled. -At 8:55 a.m. NA-D stood up and continued to feed R165. NA-D was feeding R165 with thickened liquid contained in a plastic cup while he remained standing on R165's left side. The two plastic cups on R165's table were observed to be empty, while there were two bowls with about 75% of unfinished food in each. -At 8:58 a.m. NA-D wiped R165's mouth with the clothing protector, took the clothing protector off R165's neck, put it on the table, and then moved R165's wheelchair. NA-D never talked to R165 before or while doing all these actions. -At 9:00 a.m. NA-D went on to push R165's wheelchair out from the dining room to the hallway and to R165's room. NA-D pushed R165 in wheelchair inside the room towards R165's bed, the room door was left open. NA-D positioned R165's wheelchair to face door, then locked the wheelchair brakes. NA-D placed call button on R165's lap then left the room, still without talking to R165. -At 9:04 a.m. R165 looked towards the door when surveyor knocked and signified to enter room. R165 was able to maintain eye contact when greeted. R165 nodded when surveyor asked to verify that NA-D never talked all through the time NA-D was with R165 from the dining room to R165's bedroom and until NA-D left the room. However, when surveyor re-phrased question to ask if NA-D talked or explained what he was doing, R165 just stared at surveyor then moved head to look at the television show on roommate's side. The Diagnosis Information section of R165's electronic Admission Record indicated R165 was	2 565		

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2 565	Continued From page 6 admitted on 12/20/13, with diagnoses including dizziness and giddiness, pneumonia, diabetes, dementia, depressive disorder, and paralysis agitans also known as Parkinson's disease (characterized by shaking of fingers and hands, muscle rigidity and shuffling gait). It was further indicated R165 was enrolled for palliative care on 12/3/14. The Care Area Assessments (CAA) dated 9/24/14, indicated R165 had problem with communication, and had limited English speaking ability, as would only able to understand some and communicate some. The CAA indicated staff to "use simple means of communication" to include gestures and communication book. The CAA also indicated R165 had problem with psychosocial well-being related to change in communication, and with the diagnoses of dementia and depression. R165's current care plan, initiated on 12/23/13, indicated R165's safety was at risk in relation to medical conditions and clinical manifestations to include altered mental status and limited ability to communicate in English. The care plan directed staff to do the following interventions: explain all procedures and cares before performing them; provide reality orientation while giving care; use short phrases and questions which require yes or no answers and use gestures as needed; use verbal reminders which assist patient in orientation; explain what is going on in the environment; use communication book or pictures as needed to help with communication; and provide with interpreter as needed. On 12/17/14, at 1:12 p.m. NA-F stated R165 understood English but could not speak the language. NA-F stated R165 would nod if there	2 565		

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2 565	Continued From page 7 was something R165 agreed with or wanted but R165 would shake head if did not want something. NA-F further described R165 as "a nice guy" and never called for help so staff would just have to go "check every two hours." -At 1:21 p.m. NA-D stated R165 understood English but "would take time." NA-D added R165 would nod if was in agreement with something. NA-D did not deny surveyor's observations that he did not give any explanations regarding his actions during the time he was with R165 in the dining room for breakfast until he took R165 back to room and until he left. NA-D did not deny that he did not give any environmental re-orientation to R165 during the time he was observed with R165. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated it was her expectation for staff to follow care plans of residents, for staff to talk to and explain procedures and cares to residents before doing them. The facility's Social Services Policies and Procedures Manual, Section 7: Residents' Rights, Subject: SS-702 Dignity dated as revised on 10/09, indicated all residents will be treated with respect and dignity, so as to enhance each resident's self-worth and improve his/her psychosocial well-being and quality of life. The policy directed staff to speak to residents in a friendly and patient manner, and to focus on the resident as an individual when talking to them. R128's room was observed on 12/17/14, at 7:22 a.m. The door was wide open and the lights were off. R128 was lying on his back.	2 565		

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2 565	Continued From page 8 - At 7:54 a.m. observed NA-C pull bedside drawer open and obtained pea size amount of Ketoconazole cream (used to treat a range of fungal skin infections) and applied the cream to the resident's back. When NA-C opened the drawer there were medications that were observed to be stored in the drawer. - At 7:57 a.m. the observed medications in the drawer included Ketoconazole 1% shampoo, Ketoconazole cream 2%, Nystatin cream (used to treat fungal infections) 100,000 units, Albuterol inhaler (breathing medication) and budesonide inhaler (breathing medication). Both inhalers were noted to have a different name on them which was not R128's. The Cognitive loss/dementia CAAs dated 9/17/14, identified R128 had Alzheimer's and dementia. R128 was also hard of hearing which could impact his cognition and cares. The CAA directed staff to continue to provide for his needs. The physician Order Summary Report dated 11/3/14, revealed the Ketoconazole shampoo and cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers. R128's Self-Medication Administration care plan dated 12/16/14, indicated the R128 would safely administer medications. The care plan directed staff to store medications in a secure location and there would be a periodic safety assessment/evaluation of R128's ability to administer medications. Assessment of Self-Administration of Medications dated 12/16/14, indicated R128 able to self-administer medications with setup by Nurse/TMA and nursing was responsible for storage and for documentation.	2 565		

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2 565	Continued From page 9 On 12/18/14, at 8:11 a.m. the director of nursing (DON) stated her expectation regarding storing medications to be self-administered in a resident's room stated, "The medications should not be in his room." DON further acknowledged the care plan was not being followed. The facility Medication Administration-Preparation and General Guidelines Self-Administration of Medications policy dated 2006, (Revised November 2011) directed "in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." Procedures A. "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process." F. "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. Conditions outlined in 4.3: BEDSIDE MEDICATION STORAGE are met for bedside storage to occur." SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for following the care plan and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance.	2 565		

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2 565	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate sized mattress were in place to prevent accidents and injuries for 9 of 122 residents in the facility (R126, R226, R150, R148, R136, R28, R87, R224, R72). In addition, two unoccupied rooms were identified in the facility room audit, for ill fitting mattresses (W113 and E262). Findings include: R126 On 12/15/14, at 8:07 p.m. R126's bed was observed to have a big gap between the edge of the mattress and the bed's foot board. The mattress was observed to be too short for the bed	2 830		

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2 830	Continued From page 11 frame. On 12/16/14, at 11:25 a.m. surveyor asked maintenance director (Other)-B to measure the mattress against the bed frame. Other-B measured the gap between the mattress and the foot board to be 4.75 inches and the gap between the mattress and the head board was 2.5 inches. Other-B confirmed that R126's mattress was 7.25 inches shorter than the bed frame. Other-B then placed the gap-filler he was holding to fill the gap on R126's foot part. On 12/17/14, at 1:01 p.m. the gap-filler that was placed by Other-B in R126's bed was no longer in R126's bed. The mattress was held in place by what looked like a wire holder. The gap between the mattress and the foot board was observable from the hallway as R126's room door was open during the days of survey. R126's current care plan initiated on 3/25/13, indicated R126's safety was at risk related to diagnosis of diabetes with neuropathy, retinopathy, and increased cognitive impairment. The care plan further described R126 to have poor safety awareness and impaired judgment. The care plan directed staff to remove R126 from potentially dangerous situations. R126 had diagnoses including dementia, uncontrolled diabetes, mild cognitive impairment and visual impairment related to diabetes. R226's care plan dated 12/5/14, indicated at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The Care Area Assessment (CAA) dated 12/12/14, indicated risk of falls related to	2 830		

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2 830	Continued From page 12 difficulty sequencing tasks, difficulty stabilizing when first standing and antipsychotropic medications. The Minimum Data Set (MDS) dated 12/8/14, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 (mild cognitive impairment), and required staff assistance for sequencing of daily activities. The facility bed audit it was noted the mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a "temporary" bolster was added for safety. On 12/18/14, at 10:36 a.m. the facility stated they did not have enough bolsters available and so purchased round flexible foam noodles (swim noodles), cut them into three pieces and "securely" taped the three pieces into a triangle shape and identified it as a "temporary bolster." On 12/18/14, at 3:00 p.m. the mattress was replaced. R150's MDS dated 11/6/14, indicated a BIMS score of 7/15 (severe cognitive impairment), was moderately depressed and rejected cares one to three days during the assessment period. R150 required extensive assist of two staff for bed mobility and toilet use, and limited assist of one staff for transfers, and supervision to walk in the room. The CAA dated 11/7/14, indicated R150 moves from a flat affect and isolating to smiling and socializing, and her daily needs vary. Staff assist with transfers and mobility to maintain safety. R150's care plan dated 11/27/14, identified at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit, R150 required assistance with bed mobility as needed. During a facility bed audit it was noted that R150's	2 830		

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2 830	Continued From page 13 mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a bolster was added for safety. R148's CAA dated 7/29/14, indicated R148 was at risk for falls related to balance, wandering and medication use. The care plan dated 8/4/14, indicated insomnia, sleep disturbances, and indicated at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The MDS dated 10/28/14, indicated a BIMS score of 14/15 (no cognitive impairment), was mildly depressed and did not reject cares or wander during the assessment period. R148 was independent in transfers and required cueing for toilet use. During a facility bed audit it was noted that R148's mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a bolster was added for safety R136's care plan dated 10/28/14, indicated at risk for falls and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper. The CAA dated 10/30/14, indicated a history of falls prior to admission and at risk of falls. R136 was re-admitted to the facility on 11/28/14, with admission diagnosis of depression, episodic mood disorder and generalized anxiety per the admission record. A discharge MDS dated 11/28/14, indicated a BIMS score of 13/15 (no cognitive impairment), was moderately depressed, and had verbal behavioral symptoms daily, and rejected care one to three days during the assessment period. R136 required limited assistance in transfers, toilet use, bed mobility	2 830		

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2 830	Continued From page 14 and used a four-wheeled rolling walker to ambulate on the unit and in her room. The medical record lacked evidence of an assessment of the mattress on the bed. During a facility bed audit it was noted that R136's mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a bolster was added for safety. R28's MDS dated 10/2/14, indicated short term and long term memory problems with fluctuating inattention and psychomotor retardation. R28 was severally depressed and did not reject cares or wander during the assessment period. R28 required two person limited assistance for bed mobility, one person limited assistance for toilet use and supervision for transfers and to walk in room. The care plan dated 11/22/14, indicated at risk for falls related to use of medication, impaired cognition, weakness and fatigue, and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The CAA dated 12/4/14, at risk for falls related to balance problems during transition and antipsychotic medications. During a facility bed audit it was noted that the mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a "temporary" bolster was added for safety. On 12/18/14, at 3:00 p.m. the mattress was replaced. R87 R87's annual MDS dated 9/9/14, indicated a BIMS of 10/15 (moderate cognitive impairment). R87 was mildly depressed and did not reject cares or wander during the assessment period.	2 830		

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2 830	Continued From page 15 R87 required one person extensive assistance for bed mobility, toilet use, and transfers; and limited assistance of one staff to walk in room. The CAA dated 9/22/14, indicated at risk of falls related to dementia and psychiatric conditions. The care plan dated revised 12/14, indicated at risk of falls related to use of medication, dementia and Parkinson's disease, and identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and anti-tipper, but lacked an assessment of the bed/mattress for proper fit. The incident/accident reports were reviewed and revealed the following: - On 1/16/14, at 10:00 a.m. R87 was found sitting on the floor next to her bed, stated she had been in bed and slid out. - On 4/19/14, at 5:41 a.m. R87 was found sitting on the floor beside the bed, stated she had slipped off the edge while trying to reach her shoes. - On 4/19/14, at 10:05 a.m. R87 was found on her knees next to the bed and stated the floor was slippery when she tried to get into bed. - On 10/5/14, at 2:00 p.m. R87 was found on the floor next to the bed, and stated she was sitting on the edge of the bed and reaching for something on the floor when she slid off the bed. R224 R224 Was admitted to the facility on 12/13/14, with admission diagnosis of sleep pattern disturbance and convulsions. A MDS was not available (recent admission). A care plan dated 12/14/14, indicated R224 was at risk of falls related to use of medication and new environment; the care plan identified assessing the wheelchair for appropriate size, need for footrests, locked/unlocked for safety and	2 830		

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2 830	Continued From page 16 anti-tipper, but lacked an assessment of the bed/mattress for proper fit. During a facility bed audit it was noted that the mattress did not fit the bed and a bolster was needed to prevent possible entrapment, a "temporary" bolster was added for safety. On 12/18/14, at 3:00 p.m. the mattress was replaced. R72: On 12/16/14, at 12:53 p.m. R72's bed was observed with the Alzheimer's director (AD) and the assistant director of nursing (ADON). A 5 inch gap was measured at the end of the bed from the mattress to the foot board. The AD and the ADON had not been aware the mattress did not fit the bed. The ADON explained there was a system for staff to directly report to maintenance any problems with the beds or mattresses. She verified the mattress had not been reported. On 12/17/14, at 11:45 a.m. a bolster cushion was observed at the end of the mattress to fill the gap and prevent the mattress from moving. R72 had a significant change MDS completed on 4/22/14, and the subsequent CAA Summary indicated R72 was identified as being at risk for falls and that the facility would care plan the falls. However, the CAAs did not identify the the mattress as a potential fall risk. R72's quarterly MDS dated 7/22/14, identified R72 as having two falls with injury (since the last MDS) such as skin tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains; or to have the resident complain of pain. R72's quarterly MDS dated 10/22/14, identified R72 as having two falls without injury and two falls with injury (since the last MDS) such as skin	2 830		

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2 830	Continued From page 17 tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains; or to have the resident complain of pain. R72 was placed at risk for falls as the facility did not identify the ill-fitting mattress as a potential accident hazard. The care plan for R72, updated 10/22/14, indicated R72 was at risk for falls related to use of medication, new environment, history of falls, dementia, and chronic anxiety. The goal was for no falls or fall related injuries. Approaches included activity programming and exercises, assessment for pain ever shift, and asses the wheelchair for proper fit and safety. A lipped mattress with cut out was added as and intervention on 1/7/14. On 12/18/14, at 10:36 a.m. the director of nursing (DON) and director of environmental services (DES) were interviewed regarding potential patient entrapment issues, in the patent rooms where the mattresses did not fit the beds properly. When asked what rooms had improvised bolsters, and what rooms had bolsters added, the DON stated "I do not know off the top of my head." "We had some (bolsters) on hand, and had to make some temporary (bolsters) then had to order I think 10." The temporary bolsters were created when the facility went to the store and purchased foam swim noodles, cut them and "securely taped them together" then used as a bolster for five occupied beds. The DES stated the usual process when a mattress did not fit a bed properly was nursing would put a work order into Engines (a facilities software program), then facilities would put in a bolster, or if a lip mattress was needed, facilities would change the mattress. The DON added Engines was set up in all computers and kiosks, so everyone can put in a work order.	2 830		

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2 830	Continued From page 18 -The Safety Committee met once per month, and was facilitated by the administrator. -Room set up was an interdisciplinary process, the admissions director did the final check of the room for readiness. -There was a check list to ensure things were ready, but it did not include checking the mattress on the bed. -A list of the work order for mattress changes in Engines was requested from the DES (but not provided). A review of the facility fall totals per month revealed November 2013 - 29 falls, December 2013 - 28 falls, January 2014 - 19 falls, February - 17 falls, March - 28 falls, April - 30 falls, May - 36 falls, June - 39 falls, July - 29 falls, August - 26 falls, September - 32 falls, October - 27 falls, November - 24 falls. A total of 364 falls in the 13 months since the prior survey. A review of the 2014 facility turnover rate showed a 59.7% turnover in nursing assistant (NA)/Aide, a 27.4 % turnover in licensed practical nurse (LPN)/licensed vocational nurse (LVN), and a 23.6% turnover in registered nurse (RN) staff. On 12/19/14, at 9:30 a.m. the DON stated the rates included all turnover by job class, and was not specific to unwanted turnover. A review of the resident council complaints of lack of call lights being answered for July, August, and September 2014, with no explanation of what was done to resolve the situation. On 12/18/14, at 2:45 p.m. a consultant with Health Care Services Group (housekeeping services) stated his staff would review mattresses for rips or un-cleanable surfaces which they report, but do not review to see if the mattress fit	2 830		

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2 830	Continued From page 19 the bed properly. On 12/17/14, at 3:00 p.m. The Safety Committee Meeting minutes were reviewed for three months, and did not address the mattresses/beds in any way. On 12/17/14, at 3:30 p.m. the manufactures instructions for the bed say "a mattress at least 4 inches thick and of the recommended dimensions [the dimensions are not in the hand out]. Do not use without a special mattress designed to bend and conform to the shape of the bed." On 12/18/14, at 10:36 a.m. an interview with the DON and DES the facility did not have enough bolsters available and so purchased round flexible foam noodles (swim noodles), cut them into three pieces and "securely" taped the three pieces into a triangle shape and identified it as a "temporary bolster." The DON and DES verified the facility had jerry-rigged a temporary bolster for three occupied beds, which had not been obtained from an approved manufacturer of health care products. On 12/18/14, at 12:30 p.m. The facility put together a 7 zones of entrapment education piece and educated everyone working in the facility currently, and will educate the evening shift when they arrive. On 12/18/14, at 3:00 p.m. all of the ill fitting mattresses were replaced with properly fitted mattresses obtained from storage, and from a sister facility. On 12/19/14, at 2:00 p.m. the DON stated in October of 2014, the facility had realized that the incident reports and fall huddle forms were not	2 830		

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2 830	Continued From page 20	2 830		

completed and provided re-education to the line staff on how to do the post fall huddle and document on the forms for more complete information for analysis of cause. "Our thoughts were we wanted to get more to the root cause to reduce the number of falls and eliminate repeat falls." The fall forms are reviewed in IDT (Interdisciplinary Team) meeting weekly.

The Falls Management Guideline, dated 6/12/14, directed:
*pre-admission intake assessment to assure appropriate fall interventions are in place prior to admission
*new admission assessed for fall risk and immediate plan of care for falls initiated.
*"fall alert" communication.
*fall risk brochure provided to resident/family.
*IDT team evaluates the fall prevention plan.
*Complete Minimum Data Set and Care Area Assessments and care plan updated.
*Following a fall, resident is assessed by licensed nurse and initiates the Change In Condition Report - Post Fall/Trauma, physician/representative notified. Appropriate interventions implemented, Care Plan updated.
*Continue ongoing assessment QA Falls Intervention Tracking (a quality form), licensed nurse initiates DQI Quality Control Report, reported on 24 hour report, IDT team reviewed and makes additional recommendations within 72 hours.
*QAPI (Quality Assurance Performance Improvement) committee minutes reflect data analysis..... to identify systemic trends and patterns.

SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident

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2 830	Continued From page 21 schedules and family preferences and make any necessary revisions to facility paperwork. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure universal precaution was observed for the care of gastrostomy tube (g-tube); and facility did not ensure gastric residual was checked and proper positioning was implemented during feeding and prior to medication administration via g-tube for one resident (R73) observed for medication administration through g-tube.	2 930		

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2 930	Continued From page 22 Findings include: On 12/18/14, at 7:26 a.m. a series of actions observed regarding the process of medication administration through g-tube, included the following: R73 was observed to be lying in bed with head of bed elevated about 10 to 15 degrees. An ongoing tube feeding was observed, with a bottle that contained approximately 50 milliliters (ml) of feeding formula attached to R73 through g-tube. Licensed practical nurse (LPN)-E did not correct nor made sure R73 was in the right position for tube feeding. LPN-E turned off the tube feeding then disconnected tube from the g-tube connection site. LPN-E did not pinch off or clamp the tube. LPN-E placed the open end of the g-tube on R73's undraped abdominal skin area and hanged the disconnected tube where the formula bottle was on the pole. LPN-E took syringe from bedside table, aspirated water from water bottle, but pushed water out and back to water container when he realized he had to check g-tube placement first. LPN-E took a small white towel from bedside table then picked up the open end of the g-tube from R73's abdominal area, draped the abdominal skin area with the towel, then connected the piston syringe to the g-tube. LPN-E again disconnected the piston syringe from the g-tube when he realized having to measure air first. LPN-E did not pinch off or clamp the g-tube. LPN-E measured about 15 ml of air then re-connected the syringe to the g-tube.	2 930		

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2 930	Continued From page 23 LPN-E injected the air while listening on the gastric area with the use of his stethoscope. LPN-E did not pull back to check gastric residual. LPN-E disconnected the piston syringe again from the g-tube without pinching off the g-tube, placed the open end on the towel-draped abdominal area, then holding the syringe, he pulled the plunger out from the barrel, then re-connected syringe barrel to g-tube. The nurse manager, LPN-C entered the room while LPN-E was telling surveyor that he was to flush g-tube first with 30 ml of water. LPN-E picked up water bottle and was about to pour water in the syringe without pinching off or clamping the tube but was stopped by LPN-C who then coached LPN-E to pinch off the tube first and also to first measure 30 ml of water for flushing. LPN-C instructed LPN-E to wait while LPN-C went out to get a 30 ml medication cup which LPN-E then used to measure the water for flushing. After all the due medications were given, with water flushes in between and final 30 ml flush at the end, LPN-E re-connected the feeding tube and turned the feeding pump on. LPN-E did not talk to R73 during the entire procedure of medication administration, and to check how R73 was feeling. LPN-E did not tell R73 that he was done giving medication. LPN-E then placed call light on R73's abdominal area, told surveyor he was done, and stepped out from the room. The water bottle which still contained water that turned cloudy from the medications and the syringe used for medication administration were left at R73's bedside table. The electronic Admission Record indicated R73	2 930		

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2 930	Continued From page 24 was admitted on 2/11/08, with diagnoses to include acute respiratory failure, bleeding of the gastrointestinal tract, intestinal infections, and cerebrovascular disease. R73's current care plan initiated on 10/8/10, indicated R73 was dependent on tube feeding related to dysphagia (difficulty swallowing). Facility staff were directed to implement interventions which included elevating head of bed at least 30 to 45 degrees during feeding and to apply slight pressure to tube feeding syringe with flushes and medication administration. On 12/19/14, at 8:30 a.m. LPN-C agreed that nurses should not be left alone to do procedures they were not trained to do as it would be unsafe practice for the residents. LPN-C stated nurses were expected to check g-tube placement, gastric residuals, elevate head of bed as tolerated by residents, and talk to residents to check if they were all right. On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated nurses were expected to follow proper procedures in medication administration through the g-tube to include aseptic technique and placing a drape to protect the g-tube and not just leave the open end lying on top of resident's bare abdominal skin. DON also stated emphasis to staff about explaining procedures before performing them. The facility's policy for Administration of Enteral Feeding with last review dated 11/13/14, directed staff to explain procedure to the resident; place the resident in a sitting or semi-sitting position, with the head of bed elevated at least 30 degrees during the feeding and for at least an hour after the feeding; check placement by injecting 10 to	2 930		

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2 930	Continued From page 25 15 ml of air then slowly draw back to check gastric contents; pinch off g-tube below the port so air does not enter the stomach, do not let syringe run empty or pinch off g-tube before it runs empty; rinse the syringe after use; and observe the resident for signs of discomfort. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for current standards of practice for NG medication administration/care of the NG tube, and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary food service environment. This had the potential to affect all 122 residents in the facility. Findings include: A tour of the facility dining room serving kitchens	21015		

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21015	Continued From page 26 was conducted on 12/17/14, at 2:30 p.m. with the food service director (FSD) and Registered dietitian (RD)-A. The following observations were made and verified by the FSD and RD-A: The 1 east serving kitchen microwave oven had a heavy build-up of debris on the interior top surface. The inside of two of four drawers contained considerable loose debris. The outside surfaces of the cupboards were soiled with spills and stains. The 1 west serving kitchen microwave oven was soiled on the interior surfaces. The refrigerator had a large spill of juice that had dried on and sticky. The FSD verified the oven and the refrigerator had not been kept up to standards. The 2 east serving kitchen cupboards were soled on the outer surfaces. Three of four cupboards had a build-up of crumbs and debris. The interior of the drawer located under the coffee maker was wet. There were packages of coffee in the drawer that were wet and there was loose coffee grounds throughout the drawer. The 2 West serving kitchen had two of six drawers with crumbs and debris. One of the drawers contained disposable forks loose in the drawer. On 12/15/14, at 12:02 p.m. with the FSD a manual can opener was observed with a heavy thick and sticky build-up covering the blade and face of the unit. The cogs of the gears had a build up of metal shaving. The FSD said he would expect the can opener to be cleaned daily and verified it was not in a sanitary condition. A weekly equipment cleaning schedule provided by the FSD and dated 12/14/14, lacked the	21015		

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21015	Continued From page 27 inclusion of cleaning the can opener. A sanitation policy dated 2011, indicated it was the policy of the dining services department to practice proper sanitation techniques for clean equipment to prevent the outbreak of foodborne illness. SUGGESTED METHOD OF CORRECTION: The food service director or designee could review any policies, procedures or facility processes for safe food handling and make any necessary revisions. Appropriate staff could be educated regarding any changes. The food service director or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure handwashing was performed and gloves were changed after touching soiled items during the provision of cares to 1 of 3 residents (R89) reviewed for incontinence. Findings include:	21385		

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21385	Continued From page 28 On 12/17/14, at 8:42 a.m. to 9:15 a.m. observed R89 in the dining room (DR) eating her breakfast with assistance. -At 9:16 a.m. observed nursing assistant (NA)-A wheeling R89 out of the DR into her room and stationed R89's wheelchair at her bedside door observed slightly open pulled the curtain and left the room briefly and shut the door. -At 9:19 a.m. observed NA-A going to room opened the door went to R89's side of room pulled the curtain then moved R89 closer to the bed and set the call light on R89's lap and left the room. -At 9:22 a.m. NA-A was observed going back to room then left the room briefly with a clear plastic bag with trash and went into the soiled utility room. -At 9:38 a.m. observed NA-A going to room with the Hoyer lift (machine used for transferring) and shut the door upon entering NA-A indicated he was going to lay R89 down. -At 9:40 a.m. NA-A left the room stated he was going to find another staff to assist him to lay R89 down. -At 9:45 a.m. NA-A returned to room applied the lifting sheet on R89. -At 9:50 a.m. NA-B came to room. Both hooked the lift sheet to the Hoyer then communicated as they both assisted R89 off the wheelchair to her bed. -At 9:52 a.m. both cued R89 to turn her pulled the pants down removed the lift sheet. -At 9:54 a.m. to 10:00 a.m. NA-A was observed undo R89's incontinent pad stated R89 was not incontinent then proceeded to provide pericare to the front then as both NA's were turning R89 to the wall R89 started to urinate and was observed to have stool coming out. NA-B cued NA-A to change his gloves after completing the front	21385		

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21385	Continued From page 29	21385		

pericare. NA-A was observed remove his gloves and donned two pairs of gloves without washing his hands then continued to complete pericare to the bottom wiped R89 removed the bowel movement never removed gloves applied a clean incontinent pad and touched R89 clothing, bedding that was on the way and R89 exposed lower extremities with the soiled gloves turned her to the door and fastened the incontinent pad then went over to the trash can pulled the plastic bag with soiled linen and incontinent products then removed the gloves never washed hands at this time still.
-At 10:01 a.m. NA-A was observed leaving R89's room went to the soiled utility room when asked as he entered the room if he was supposed to wash his hands between glove changing and after finishing to do provide pericare he stated he was supposed to wash and change gloves. NA-A acknowledged he had not changed his gloves after wiping resident bottom after cleaning the bowel movement.
-At 10:04 a.m. licensed practical nurse (LPN)-A indicated NA-A was supposed to have changed his gloves after pericare and was also supposed to wash his hands between removing gloves "That is an infection control issue."

On 12/18/14, at 1:31 p.m. When asked what her expectation on gloving, hand washing was registered nurse (RN)-B who also was in charge of the facility infection control program stated "staff have been taught when gloves are dirty they must take gloves off, wash their hands and reapply new gloves."

Handwashing/Hand Hygiene policy revised August 2012, directed "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial soap and water under the following

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21385	Continued From page 30 conditions: n. Before and after assisting a resident with toileting (hand washing with soup and water)..." SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for appropriate hand hygiene during cares and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R128, R124) was safe to self-administer medications. Findings include: R128's room was observed on 12/17/14, at 7:22 a.m. The door was wide open and the lights were off. R128 was lying on his back. - At 7:54 a.m. observed nursing assistant (NA)-C	21565		

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	00872	A. BUILDING: _____ B. WING _____	12/19/2014

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21565	Continued From page 31	21565		

opened the bedside drawer and obtained pea size amount of Ketoconazole cream (used to treat a range of fungal skin infections) and applied the cream to the resident's back. When NA-C opened the drawer there was medications that were observed to be stored in the drawer.
- At 7:57 a.m. the observed medications in the drawer included Ketoconazole 1% shampoo, Ketoconazole cream 2%, Nystatin cream (used to treat fungal infections) 100,000 units, Albuterol inhaler (breathing medication) and budesonide inhaler (breathing medication). In addition, both inhalers were noted to have a different name on them which were not R128's. R128 was not able to converse at the time of observation.

The Cognitive loss/dementia Care Area Assessment (CAAs) dated 9/17/14, identified R128 had Alzheimer's and dementia. R128 was also hard of hearing which could impact his cognition and cares. The CAA directed staff to continue to provide for his needs.

The physician Order Summary Report dated 11/3/14, revealed the Ketoconazole shampoo and cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers.

R128's Self-Medication Administration care plan dated 12/16/14, indicated the R128 would safely administer medications. The care plan directed staff to store medications in a secure location and there would be a periodic safety assessment/evaluation of R128's ability to administer medications.

Assessment of Self-Administration of Medications dated 12/16/14, indicated R128 able to self-administer medications with setup by Nurse/TMA and nursing was responsible for

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21565	Continued From page 32 storage and for documentation. On 12/18/14, at 8:11 a.m. the director of nursing (DON) stated her expectation regarding storing medications to be self-administered in a resident's room stated, "The medications should not be in his room." R128 did not have an order for the inhalers and did not have an order to self-administer the inhalers. R128 was not administering their medications in a safe manner nor did the facility store the medications in a safe manner for R128 to self-administer. R124's room was observed on 12/15/14, at 4:00 p.m. and a bottle of Refresh eye drops (artificial tears for dry eyes) was on R124's bedside table. R124 claimed to own the bottle of eye drops and stated had to "use it three times a day" as recommended by "eye doctor." R124 further stated to have had the medication "all the time" at bedside table and instilled the eye drops to eyes by herself. -At 4:02 p.m. licensed practical nurse (LPN)-F came to R124's room and confirmed the presence of the eye drops on R124's bedside table. -At 4:04 p.m. LPN-F verified R124 did not have a doctor's medication order for the Refresh eye drops. LPN-F stated he would "take care of it." R124's care plan initiated on 11/29/11, indicated R124 as a resident of the nursing facility was receiving "care from someone else" and whose "safety is at risk." The care plan directed staff to remove R124 from potentially dangerous situations. The care plan also indicated R124 had impaired vision related to macular degeneration. The interventions section of the care plan was	21565		

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21565	Continued From page 33 updated on 12/15/14, to add R124 can self-administer Refresh eye drops and bottle of eye drops to be kept at R124's bedside. The Medication Administration Record (MAR) dated 12/01 through 12/31/14, indicated an update was entered on 12/15/14, reflecting the addition of the eye drops to R124's medication list. The MAR update read, "Refresh Tears Solution [Carboxymethylcelluslose Sodium] Instill 2 drops in both eyes three times a day for DRY EYES OK PER EYE DR TO SELF ADMINISTER AND KEEP AT BEDSIDE." On 12/19/14, at 8:52 a.m. the DON stated staff were expected to check medications that residents brought in to the facility, interview residents and discuss the medications; staff were to obtain proper orders for all medications; assess residents for safety in self-administration of medications; and ensure in safe keeping for medications. The facility Medication Administration-Preparation and General Guidelines Self-Administration of Medications policy dated 2006, (Revised November 2011) directed "in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." Procedures A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process." F. "Bedside medication	21565		

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21565	Continued From page 34 storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. Conditions outlined in 4.3: BEDSIDE MEDICATION STORAGE are met for bedside storage to occur." SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for self administration of medications and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21590	MN Rule 4658.1330 Written Authorization for Administering Drugs All medications, including those brought into a nursing home by a resident, must be administered only in accordance with a written order signed by a health care practitioner licensed to prescribe in Minnesota except that order may be given by telephone provided that the order is done according to part 4658.0455. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 residents (R128, R124) had physician orders for the medication(s) they self-administered. Findings include:	21590		

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21590	Continued From page 35 R128's room was observed on 12/17/14, at 7:22 a.m. The door was wide open and the lights were off. R128 was lying on his back. - At 7:54 a.m. observed nursing assistant (NA)-C pull bedside drawer open and obtained pea size amount of Ketoconazole cream (used to treat a range of fungal skin infections) and applied the cream to the resident's back. When NA-C opened the drawer there were medications that were observed to be stored in the drawer. - At 7:57 a.m. the observed medications in the drawer included Ketoconazole 1% shampoo, Ketoconazole cream 2%, Nystatin cream (used to treat fungal infections) 100,000 units, Albuterol inhaler (breathing medication) and budesonide inhaler (breathing medication). Both inhalers were noted to have a different name on them which was not R128's. R128 was unable to converse at the time of the observation. The Cognitive loss/dementia Care Area Assessment (CAAs) dated 9/17/14, identified R128 had Alzheimer's and dementia. R128 was also hard of hearing which could impact his cognition and cares. The CAA directed staff to continue to provide for his needs. The physician Order Summary Report dated 11/3/14, revealed the Ketoconazole shampoo and cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers. R128's Self-Medication Administration care plan dated 12/16/14, indicated the R128 would safely administer medications. The care plan directed staff to store medications in a secure location and there would be a periodic safety assessment/evaluation of R128's ability to administer medications.	21590		

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21590	Continued From page 36 Assessment of Self-Administration of Medications dated 12/16/14, indicated R128 able to self-administer medications with setup by Nurse/TMA and nursing was responsible for storage and for documentation. On 12/17/14, at 8:20 a.m. LPN-A was asked if R128 could self-administer medications. RN-A stated, "He cannot administer medications himself." On 12/18/14, at 8:11 a.m. the director of nursing (DON)stated her expectation regarding storing medications to be self-administered in a resident's room stated, "The medications should not be in his room." R124's room was observed on 12/15/14, at 4:00 p.m. and a bottle of Refresh eye drops (artificial tears for dry eyes) was on R124's bedside table. R124 claimed to own the bottle of eye drops and stated had to "use it three times a day" as recommended by "eye doctor." R124 further stated to have had the medication "all the time" at bedside table and instilled the eye drops to eyes by herself. -At 4:02 p.m. licensed practical nurse (LPN)-F came to R124's room and confirmed the presence of the eye drops on R124's bedside table. -At 4:04 p.m. LPN-F verified R124 did not have a doctor's medication order for the Refresh eye drops. LPN-F stated he would "take care of it." R124's care plan initiated on 11/29/11, indicated R124 as a resident of the nursing facility was receiving "care from someone else" and whose "safety is at risk." The care plan directed staff to remove R124 from potentially dangerous situations. The care plan also indicated R124 had	21590		

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21590	Continued From page 37	21590		

impaired vision related to macular degeneration. The interventions section of the care plan was updated on 12/15/14, to add R124 can self-administer Refresh eye drops and bottle of eye drops to be kept at R124's bedside.

The Medication Administration Record (MAR) dated 12/01 through 12/31/14, indicated an update was entered on 12/15/14, reflecting the addition of the eye drops to R124's medication list. The MAR update read, "Refresh Tears Solution [Carboxymethylcelluslose Sodium] Instill 2 drops in both eyes three times a day for DRY EYES OK PER EYE DR TO SELF ADMINISTER AND KEEP AT BEDSIDE."

On 12/19/14, at 8:52 a.m. the DON stated staff were expected to check medications that residents brought in to the facility, interview residents and discuss the medications; staff were to obtain proper orders for all medications; assess residents for safety in self-administration of medications; and ensure in safe keeping for medications.

The facility Medication Administration-Preparation and General Guidelines Self-Administration of Medications policy dated 2006, (Revised November 2011) directed "in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." Procedures A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to

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21590	Continued From page 38 carry out this responsibility during the care planning process." F. "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. Conditions outlined in 4.3: BEDSIDE MEDICATION STORAGE are met for bedside storage to occur." SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for current standards of practice for medication brought from home, and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21590		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility did not ensure expired medications were discarded; medication carts were kept clean. This had the potential to affect 60 of 120 residents. Findings include:	21610		

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21610	Continued From page 39 2 East Unit/ North-side Medication Cart On 12/18/14, at 11:18 a.m. during inspection of the 2 East medication cart, where the following ready to use medication were observed: A half-full bottle of facility supply Tums (medication for hyperacidity) which was expired on 9/10/14; an opened bottle of Levemir insulin and an opened bottle of Novolog insulin for R81 which had no labels as to when they were opened. The 2nd drawer was with thick, pink and white powder build up at the back. The drawer contained 17 packages of pills. In addition, the 3rd and 5th drawers of the medication cart were observed to have thick, white powder build-up on the back and sides with multiple pieces of foil and approximately 30 bubble packages of pills. On 12/18/14, at 11:36 a.m. licensed practical nurse (LPN)-E verified the presence of expired medications and medications with no dates to indicate when they were opened. LPN-E also stated nurses were supposed to clean medication carts at the end of every shift and night nurses were charged to make sure medication carts were kept clean. 2 West Unit/ West-side Medication Cart On 12/19/14, at 9:39 a.m. LPN-G agreed to check the medication cart with surveyor, where the following ready to use medication were observed: a bottle of facility supply Naproxen (pain reliever and anti-inflammatory medication) 220 milligrams (mg) which was expired on 8/14; A bottle of mineral oil with no name written and also had no expiration date; R101's Trixaicin cream (pain reliever cream) and a Silverstat antibacterial wound dressing ointment had no expiration dates; and R118's Atropine sulfate (used to dilate the	21610		

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21610	Continued From page 40 eye and reduces eye discomfort) 1% solution which was expired on 11/14. The middle drawer of the medication cart was also observed to be dirty with white powdery substances. A medication/treatment bin placed in the 4th drawer of the medication cart was dirty with thick, cream-colored and greasy substance. The 4th drawer also had white powders at the back and there were four white loose pills on the drawer floor. LPN-G stated nurses were responsible in cleaning carts and making sure medications were current. LPN-G agreed the medication cart drawers were dirty and stated she clean them. 2 West Unit Medication Room On 12/19/2014, at 10:04 a.m. the 2 West Medication Room was checked with LPN-H. The following ready to use medication were observed: an open bottle of house stock of Vitamin D-400 international units (IU) with no expiration date; R141's unopened bottle of liquid Ativan (anti-anxiety medication) 2mg/ml which was expired on 8/14; LPN-H placed the liquid Ativan back to narcotic box, locked the box and put it back in the refrigerator. LPN-H stated she had to put the expired medication back in the locked box because two nurses were needed to discard it. On 12/18/14, at 11:21 a.m. the director of nursing (DON) stated nurses were expected to clean the carts. The DON added the facility's policy was not to have expired and undated medications in the medication carts and rooms. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures to monitor expiration of medications	21610		

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21610	Continued From page 41 and cleanliness of the medication cart. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21610		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by:	21630		

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21630	Continued From page 42 Based on observation, interview, and document review, the facility did not have a system to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 1 of 1 residents (R56). Findings include: Fentanyl patches disposal 1 East Floor: On 12/19/14, at approximately 9:22 a.m. a tour of the medication cart was completed with LPN-B. During the tour inside the narcotic box to the back was observed an opened box of Fentanyl patches for R56. When asked what the facility policy was for disposing used patches LPN-B stated she was not sure and would get back to surveyor after asking her supervisor. Upon reviewing the narcotic book it was revealed from 11/3/14, to 12/15/14, R56 had received the Fentanyl patch fourteen times of which only three times two nurses had documented witnessing the destruction. -At 9:25 a.m. LPN-B approached surveyor stated two nurses were supposed to witness removing the used patch, flush it in the toilet and were both to document in the narcotic book the destruction. -At 9:27 a.m. RN-E also the unit nurse manager verified the nurses were not documenting witnessing the destruction which increased the potential for diversion. RN-E further stated it was facility policy both nurses to document in the narcotic book each time. R56's Physician's Orders dated 11/5/14, indicated R56 had an order for the Fentanyl patch 72 hour 75 microgram (mcg)/hour (patch used for pain). R56's diagnoses included mylagia and myositis, hip joint replacement and aftercare for healing traumatic fracture of hip obtained from Admission	21630		

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21630	Continued From page 43 Record dated 12/12/2014. During review of R56's Electronic Medication Administration Record (EMAR) dated 12/1/14 through 12/18/14, it was revealed R56 had the Fentanyl patch removed and disposed of six times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for the removal, destruction and applying of the Fentanyl patch. On 11/6/14, at 1:42 p.m. DON stated it was the facility policy for both nurses to document immediately in the narcotic book upon completing the destruction. Controlled Substance Disposal policy dated 05/12, directed "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of |two licensed nurses|, and the disposal is documented on the accountability record/book on the line representing that dose ..." The policy did not indicate who was responsible to oversee the narcotic books were audited regularly to ensure nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion.	21630		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by:	21665		

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21665	Continued From page 44 Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R102) room was kept clean and free of odors reviewed for environmental concerns. Findings include: R102's diagnoses dementia, hemiplegia, depression, seizure disorder and chronic pain obtained from the quarterly Minimum Data Set (MDS) dated 10/9/14. In addition, the MDS indicated R102 had both short and long term memory problems, required total dependence of one staff with toilet use and all other activities of daily living and had an indwelling catheter. On 12/15/14, at 4:50 p.m. as surveyor was walking down the hallway during the initial facility tour a strong musty malodorous smell was noted outside R102's room. Looking inside the room observed R102 lying in bed and the smell faded off from the hallway when registered nurse (RN)-A entered the room and shut the door. -At 4:52 p.m. the maintenance director stated he was not able to smell as he had been on the floor for a while and would come back maybe he would be able to pick the smell up. -At 4:56 p.m. housekeeping account manager approached surveyor indicated she wanted to go into R102's room but at the time R102's wife was visiting and was assisting R102. On 12/15/14, at 5:43 p.m. housekeeping account manager indicated the smell was urine smell and she was not sure where it was coming from after going into the bathroom and started to clean the room. -At 5:44 p.m. observed housekeeping account manager on her knees spraying the floor as she wiped all under and around the bed.	21665		

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21665	Continued From page 45 -At 5:49 p.m. when asked if he had noticed the strong musty smell in the room when administering R102's medications RN-A indicated it was urine smell and further stated R102 had a suprapubic catheter and was at times incontinent and thought this is why there was a urine smell in the room. On 12/15/14, at 7:20 p.m. housekeeping account manager stated "The smell was a lot better." When asked if she would have expected staff to let her department know about the smell she stated "Yes" she further stated as she pointed to the air vent on the wall by the bathroom that when she had sprayed cleaning solution she had noticed a smell coming out of it and had thought that was where the smell was going from. On 12/16/14, at 9:10 a.m. to 3:00 p.m. room remained to have a strong urine smell. Several staff, residents and family members were observed going past the room to other rooms located down the hallway back and forth. No staff acknowledged R102's room needed to be cleaned. On 12/17/14, at 7:30 a.m. to 9:22 a.m. R102's room noted still to have a strong urine smell that was noticeable from standing or walking past the room in the hallway. R102's door was wide open at the time and several staff going by the room including the director of nursing, maintenance director and the executive administrator. -At 9:22 a.m. surveyor and licensed practical nurse (LPN)-A went to room when asked what and where the smell was coming from LPN-A stated R102 had a catheter bag and thought that was where the smell was coming from and indicated he would change the catheter bag to see if the strong urine smell would fade off.	21665		

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21665	Continued From page 46 -At 9:30 a.m. both maintenance director and housekeeping account manager approached the room both acknowledged the smell was urine and when maintenance director was asked to enter the room he stated he was able to smell the urine smell from standing outside the room in the hallway. Maintenance director further stated "Let us figure this out we are thinking it's the mattress" he turned to the housekeeping account manager and asked what time she wanted housekeeping to coordinate with nursing to get R102 up for the room to be deep cleaned. On 12/18/14, at 8:16 a.m. the director of nursing (DON) stated she and the executive director had identified the urine smell on 12/17/14, but was not sure of the time and had started to coordinate for R102's room to be cleaned. When asked if she expected staff to have reported the smell to housekeeping as soon as it was notice DON stated "Of course." On 12/19/14, the housekeeping policy was requested but was not provided instead in-service content was provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for reporting a malordous room for deep cleaning, and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure dignified treatments were implemented for two residents (R165, R85) observed in the dining room and to one resident (R73) observed for medication administration through gastrostomy tube (g-tube). In addition, the facility failed to offer the residents a choice of condiments at meals. This had the potential to effect all 35 residents on the 2 west unit. Findings include: R165 On 12/17/14, at 8:45 a.m., R165 was observed at the 1 East dining room, seated in wheelchair and with two other residents at the dining table. Nursing assistant (NA)-D was seated in a chair on R165's left side and was feeding R165. There was no verbal cueing heard or any other form of communication observed between NA-D and R165, aside from the acts of NA-D giving spoons-full of food to R165. Surveyor was within range from R165's table enough to have heard any regular tone of conversation such as that from another resident at the same table, R125, who told NA-D about wanting to go back to room but NA-D did not say a word, nodded his head, and	21805		

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continued to feed R165. In addition, R165 was observed for at least three times having spilled food from mouth down to clothing protector, as was observed to only take small bites from the spoon full of food being fed by NA-D. For each time that food were being spilled from R165's mouth, NA-D used R165's clothing protector to wipe the corners of R165's mouth and chin.
-At 8:55 a.m. NA-D stood up and continued to feed R165. NA-D was feeding R165 with thickened liquid contained in a plastic cup while he remained standing on R165's left side. The two plastic cups on R165's table were observed to be empty, while there were two bowls with about 75% of unfinished food in each.
-At 8:58 a.m. NA-D wiped R165's mouth with the clothing protector, took the clothing protector off R165's neck, put it on the table, and then moved R165's wheelchair. NA-D never spoke to R165 before or while doing all these actions.
-At 9:00 a.m. NA-D went on to push R165's wheelchair out from the dining room to the hallway and to R165's room. NA-D pushed R165 in wheelchair inside the room towards R165's bed; the room door was left open. NA-D positioned R165's wheelchair to face door, then locked the wheelchair brakes. NA-D placed call button on R165's lap then left the room, still without talking to R165.
-At 9:04 a.m. R165 looked towards the door when surveyor knocked and signified to enter room. R165 was able to maintain eye contact when greeted. R165 nodded to agree when surveyor asked to verify that NA-D never talked all through the time NA-D was with R165 from the dining room to R165's bedroom and until NA-D left the room. However, when surveyor re-phrased question to ask if NA-D talked or explained what he was doing, R165 just stared at surveyor then moved head to look at the television show on

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roommate's side. When asked if R165 felt ignored about NA-D's treatment, R165 kept quiet and kept eyes on the television.

R165's current care plan, initiated on 12/23/13, indicated R165's safety was at risk in relation to medical conditions and clinical manifestations to include altered mental status and limited ability to communicate in English. The care plan directed staff to do the following interventions: explain all procedures and cares before performing them; provide reality orientation while giving care; use short phrases and questions which require yes or no answers and use gestures as needed; use verbal reminders which assist patient in orientation; explain what was going on in the environment; use communication book or pictures as needed to help with communication; and provide with interpreter as needed.

The Care Area Assessments (CAA) dated 9/24/14, indicated R165 had problem with communication, and had limited English speaking ability, as would only able to understand some and communicate some. The CAA indicated staff to "use simple means of communication" to include gestures and communication book. The CAA also indicated R165 had problem with psychosocial well-being related to change in communication, and with the diagnoses of dementia and depression.

The Diagnosis Information section of R165's electronic Admission Record indicated R165 was enrolled for palliative care on 12/3/14.

R165's Minimum Data Set (MDS) for significant change in status dated 12/10/14, indicated R165 did not speak words, and rarely had the ability to make self-understood nor to understand others.

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21805	Continued From page 50 The MDS identified R165 to have long and short term memory loss. The MDS also indicated R165 was totally dependent on staff for all activities of daily living (ADL) to include transfers, mobility and locomotion. On 12/17/14, at 1:21 p.m. NA-D stated R165 understood English but "would take time." NA-D added R165 would nod if was in agreement with something. NA-D did not deny surveyor's observations that he did not give any explanations regarding his actions during the time he was with R165 in the dining room for breakfast until he took R165 back to room and until he left. NA-D did not deny that he was standing beside R165 while he continued to feed R165 with breakfast. R85 On 12/17/14, at 7:41 a.m. R85 room door was open. R85 was observed sitting in wheelchair beside bed, with eyes closed. The room was quiet. -At 7:44 a.m., a NA-A entered R85's room without knocking on door, approached R85, then without saying a word, started to unlock R85's wheelchair brakes. NA-A called R85's name once, touched R85's hand but R85's eyes remained closed. NA-A pushed R85's wheelchair from room to hallway then to the 2 East dining room, stopped at a table, locked wheelchair brakes then left R85 without talking to R85. -At 7:52 a.m. R85 remained seated in wheelchair on the same spot where NA-A had parked the wheelchair. R85's eyes remained closed. R85 was alone at table. There were four other residents in the dining room but no staff was present. -At 8:07 a.m. a dietary staff was observed	21805		

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working in the mini-kitchen. R85's eyes were still closed. R85 was wearing a green clothing protector.
-At 8:19 a.m. R85 had leaned head towards wheelchair's head rest, with eyes closed. No food was served at R85's table yet.
-At 8:31 a.m. R85 was still seated on the same spot in the dining room, with eyes remained closed.
-At 8:37 a.m. R85 still had eyes closed, alone at dining table. A glass of milk and a glass of orange juice were observed sitting on R85's table.
-At 8:42 a.m. a NA-C finally went to serve breakfast plate to R85. NA-C was observed providing R85 with total assistance with feeding and was talking to R85 during the entire time.

R85's electronic Admission Record dated 12/2/11, indicated R85 had urinary tract infection, Alzheimer's disease and vascular dementia.

The care plan initiated on 12/6/11, indicated R85 had cognitive loss and diminished decision making capabilities and safety and security issues. The care plan directed staff to provide environmental cues to minimize cognitive deficits. The care plan also indicated R85 wanted to remain comfortable in the nursing home. The care plan further directed staff to introduce themselves when assisting with activities of daily living and staff were to tell R85 what they were doing during cares and when assisting with meals.

R73
On 12/18/14, at 7:26 a.m., LPN-E was observed for the process of medication administration through g-tube to R73.
-R73 was lying in bed with the head of bed elevated about 10-15 degrees. An ongoing tube

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feeding was observed, with a bottle that contained approximately 50 milliliters (ml) of feeding formula attached to R73 through g-tube. LPN-E did not correct nor made sure R73 was in the right position for tube feeding. LPN-E did not explain what he was going to do to R73.
-Without saying a word to R73, Licensed practical nurse (LPN)-E turned off the tube feeding then disconnected it from the g-tube connection site.
-LPN-E administered the medications through R73's g-tube without talking to R73. LPN-E never paused to check how R73 felt. R73 was quiet during the whole medication administration procedure. R73's eyes followed what LPN-E was doing.
-After the medications were administered via R73's g-tube, LPN-E re-connected the feeding tube and turned it on. LPN-E did not verbalize to R73 that he was done giving medication. LPN-E placed the call light on top of R73's abdomen, then stepped out of the room.

R73's current care plan initiated on 4/3/13, indicated R73's safety was at risk and had potential for abuse related to decreased cognition, inability to communicate, need for total care and decreased physical ability. The care plan directed staff to explain actions before doing them; and to explain environment to help keep R73 understand what was going on around.

On 12/19/14, at 8:52 a.m. the director of nursing (DON) stated it was her expectation for staff to treat residents with dignity at all times.

The facility's Social Services Policies and Procedures Manual, Section 7: Residents' Rights, Subject: SS-702 Dignity dated as revised on 10/09, indicated all residents will be treated with respect and dignity, so as to enhance each

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21805	Continued From page 53 resident's self-worth and improve his/her psychosocial well-being and quality of life. The policy directed staff to speak to residents in a friendly and patient manner, and to focus on the resident as an individual when talking to them. In addition, the policy directed staff to respect residents' private space and property. Condiments: On 12/16/14, at 8:30 a.m. at breakfast, there were no evidence of salt or pepper shakers on the tables, and there was no evidence of any salt or pepper packets having been used. There were also no sugar packets available on the tables. - At 8:35 a.m. nursing assistants (NA)-G, NA-H were interviewed and stated they were to ask if residents wanted salt or pepper. During the meal observation there was no observation of staff in the dining room asking residents if they wanted salt and/or pepper. The tables were void of empty packets on the tables. Residents were observed eating their eggs without salt or pepper. - At 8:45 a.m. Cook-A and the assistant director of nursing explained, there were salt and pepper packets in the cupboard and the residents would need to ask for it. They went on to explain salt and pepper shakers were used in the past, but residents would sometimes pour too much on their food or unscrew the top, so they do not put them out anymore. They verified that not all resident were able to request condiments. On 12/17/14, at 7:45 a.m. the cupboards in the dining room were observed and there large plastic bags of salt and pepper packets available for the staff to offer the residents. The residents were not afforded the choice of sugar, salt and/or pepper for the food that was served.	21805		

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21805	Continued From page 54 SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for treating resident's with dignity and make any necessary revisions. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		