DEPARTMENT OF HEALTH A	ND HUMA	N SERVICES			CENTERS FOR MEE	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAII	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 36LS
	PART I -	TO BE COMPL	LETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 00872
1. MEDICARE/MEDICAID PROVIDER N (L1) 245293 2.STATE VENDOR OR MEDICAID NO. (L2) 417633200	0.	3. NAME AND AE (L3) GOLDEN L 1 (L4) 725 SECON 1 (L5) HOPKINS , N	IVINGCENTI D AVENUE SO	ER - HOPH	(L6) 55343	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 11/01/2002	ERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 2/18/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	15 (L34) (L10)	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC			14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	138 (L18)	Compliance		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	<u>The Following Requirements:</u> 6. Scope of Services Limit 7. Medical Director (F) <u>X</u> 8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	138 (L17)		pliance with Prog ents and/or Appli		* Code: A, 8*	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF 138	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK Facility's request for a continuing wa				,	led.	
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Magdalene Jares, HFE NE II		0	2/20/2015	(L19)	Anne Kleppe, Enforcer	ment Specialist 03/23/2015 (L20)
PART	I - TO BE	COMPLETED F	BY HCFA RF	EGIONAI	COFFICE OR SINGLE S	
 19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Partici 2. Facility is not Eligible 	pate (L21)		IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
22. ORIGINAL DATE 23						4.00
OF PARTICIPATION 10/01/1985	LTC AGREE		4. LTC AGREEN ENDING DA		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. (L27)	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active	
	D. Rescillu S	uspension Date.	(L45)			
28. TERMINATION DATE:	29). INTERMEDIARY/			30. REMARKS	
	(L28)	00040		(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
(L32)	02/02/2015		(L33)	DETERMINATION APPI	ROVAL



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,

Ane Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Golden Livingcenter - Hopkins February 20, 2015 Page 2

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



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.

Golden LivingCenter - Hopkins February 20, 2015 Page 2

Sincerely,

Ane Klegge

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

Enclosure cc: Licensing and Certification File

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 245293	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/18/2015
Nam	e 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
	F0176 483.10(n)		Correction Completed 02/18/2015		F0241 483.15(a)		Correction Completed 02/18/2015			F0276 483.20(c)		Correction Completed 02/18/2015
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 02/18/2015	ID Prefix Reg. #			Correction Completed 02/18/2015		ID Prefix Reg. #			Correction Completed 02/18/2015
ID Prefix Reg. # LSC	F0334 483.25(n)		Correction Completed 02/18/2015	ID Prefix Reg. # LSC	483.35(i)		Correction Completed 02/18/2015			F0431 483.60(b), (d)		Correction Completed 02/18/2015
	F0441 483.65		Correction Completed 02/18/2015	Reg. #	F0465 483.70(h)		Correction Completed 02/18/2015		– "			Correction Completed
Reg. #												
State Agen	icy C	leviewed GL/AK leviewed		Date: 03/24/20 Date:	Signatur 015 Signatur		-		32982	2	Date: 02/2 Date:	18/2015
Followup	to Survey Comp 12/19/		1:							Summary of the Facility?	YES	NO

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 245293	(Y2) Multiple Cons A. Building B. Wing	° 01 - MAIN BUILDING 01			
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		Correction Completed 01/28/2015	ID Prefix		Correctio Complete 01/28/201	d	ID Prefix			Correction Completed
-	NFPA 101		•	NFPA 101			Reg. #			
LSC	K0062		LSC	K0144			LSC			
		Correction			Correctio	1				Correction
ID Prefix		Completed	ID Profix		Complete	d	ID Profix			Completed
							Dog #			
Reg. # LSC			Reg. # LSC				LSC			
		Correction			Correctio	1				Correction
ID Due fin		Completed	ID Due fin		Complete	d	ID Due fin			Completed
Reg. # LSC			Reg. # LSC				Reg. # LSC			
							-			
		Correction			Correctio					Correction
ID Prefix		Completed	ID Prefix		Complete	d	ID Prefix			Completed
Reg. #										
LSC			LSC				LSC			
ID Prefix		Correction Completed	ID Prefix		Correctio Complete		ID Prefix			Correction Completed
Reg. #							D //			
LSC			LSC				LSC			
Reviewed E	By Review	ved By	Date:	Signature	of Surveyor:				Date:	
State Agen	cy PS/A	K	02/20/20	15			2812	0	01/3	0/2015
Reviewed E CMS RO	3y Review	ved By	Date:	Signature	of Surveyor:				Date:	
Followup t	o Survey Completed 12/17/2014				y Uncorrected De d Deficiencies (YES	NO

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 245293	(Y2) Multiple Cons A. Building B. Wing	[°] 02 - 2008 ADDITION			
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	i) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 01/28/2015	ID Prefix		Correction Completed 01/28/2015	ID Prefix		Correction Completed
-	NFPA 101		-	NFPA 101	_	Reg. #		
LSC	K0062		LSC _	K0144	_	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #					
			LSC		_			
		Correction			Correction			Correction
ID Drofiv		Completed	ID Drofiv		Completed	ID Profix		Completed
ID Prefix					_			
Reg. # LSC			Reg. # LSC		_	Reg. # LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Reg. #		
LSC			LSC		_	LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #						Reg. #		
LSC			LSC _		_	LSC		
Reviewed E		iewed By	Date:	Signature of Su	irveyor:		Date:	
State Agen	cy PS	/AK	02/20/20	15		28120	01/3	0/2015
Reviewed E CMS RO	3y — Revi	iewed By	Date:	Signature of Su	irveyor:		Date:	
Followup t	o Survey Complet 12/17/20			Check for any Unco Uncorrected Def		iencies. Was a Su S-2567) Sent to the		NO



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,

Ane Klegese

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> 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 00872	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/18/2015
Nam	e 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) D	ate
	MN Rule 4658.040			MN Rule 4658.040			MN Rule 4658		
LSC			LSC			LSC			
ID Prefix Reg. # LSC	20930 MN Rule 4658.052	Correction Completed 02/18/2015 5 Subp.	ID Prefix Reg. # LSC	21015 MN Rule 4658.061	Correction Completed 02/18/2015 0 Subp.		21385 MN Rule 4658	.0800 Sul	Correction Completed 02/18/2015
ID Prefix Reg. # LSC	21565 MN Rule 4658.132	Correction Completed 02/18/2015 5 Subp.	ID Prefix Reg. # LSC	21590 MN Rule 4658.133	Correction Completed 02/18/2015 0	Rea. #	21610 MN Rule 4658	.1340 Sul	Correction Completed 02/18/2015 op.
ID Prefix Reg. # LSC	21630 MN Rule 4658.135	Correction Completed 02/18/2015 0 Subp.	ID Prefix Reg. # LSC	21665 MN Rule 4658.140	Correction Completed 02/18/2015		21805 MN St. Statute		Correction Completed 02/18/2015 Sul
ID Prefix Reg. # LSC			Reg. #						
Reviewed E State Agen	cy GL/	ewed By /AK	Date: 02/20/202		329	982		Date: 02/18/	2015
Reviewed By Reviewed By CMS RO Provide the second seco			Date:		T Surveyor: Jncorrected Defici Deficiencies (CMS		the Facility?	Date: YES 6LS12	NO

DEPARTMENT OF HE	MEDIC	ARE/MEDICAL			AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: 36LS		
1. MEDICARE/MEDICAID PRO (L1) 245293 2.STATE VENDOR OR MEDIC (L2) 417633200	OVIDER NO.	3. NAME AND AI (L3) GOLDEN L (L4) 725 SECON (L5) HOPKINS, 1	DDRESS OF FA IVINGCENT D AVENUE S	CILITY ER - HOPI	TE SURVEY AGENCY KINS (L6) 55343	Facility ID: 00872 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
8. ACCREDITATION STATUS: 0 Unaccredited 1 T	12/19/2014 (L34)	P 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA .34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF				7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30		
 11LTC PERIOD OF CERTIFIC From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	ATION 138 (L18) 138 (L17)	Complianc 1. A X B. Not in Con	nce With equirements e Based On: cceptable POC	ogram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B,8	7. Medical Director		
14. LTC CERTIFIED BED BREA	AKDOWN				15. FACILITY MEETS			
18 SNF 18/19		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L3		(L42)	(L43)					
16. STATE SURVEY AGENCY Facility's request for a cont				,				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Becky Wong, HFE N	JE II	0	01/23/2015	(L19)	Anne Kleppe, Enforcement Specialist 01/29/2015 (L20)			
	PART II - TO BE	COMPLETED I	BY HCFA R	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELI 1. Facility is Eligib 2. Facility is not E 	ble to Participate		IPLIANCE WIT HTS ACT:	'H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :		
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:	: (L30)		
OF PARTICIPATION 10/01/1985	BEGINNING	G DATE	ENDING DA	ΥТЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	of run to moorn groundin		
25. LTC EXTENSION DATE:	_,	VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change		
(L2	7)	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	O. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		00040						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVA	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



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;

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

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

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

DEPARTMENT CONTACT

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

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

Email: <u>gloria.derfus@state.mn.us</u> 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

Golden LivingCenter - Hopkins January 6, 2015 Page 4

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.

Golden LivingCenter - Hopkins January 6, 2015 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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: <u>pat.sheehan@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Golden LivingCenter - Hopkins January 6, 2015 Page 6

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulations Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> 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 PRINTED: 01/06/2015 FORM APPROVED OMB NO. 0938-0391

245293 B. WNG 12/19/2014 NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STREE, 2000E 725 GOLDEN LIVINGCENTER - HOPKINS The STREET ADDRESS, CITY, STREE, 2000E 725 MAIN OF THE MEMORY OF DEFICIENCIES PREVIDERS PLAN OF CORRECTION Condent Control PREVIDER SPLAN OF CORRECTION BUMMARY STREEMENT OF DEFICIENCIES PREVIDERS PLAN OF CORRECTION Condent Control PREVIDER SPLAN OF CORRECTION BUMMARY STREEMENT OF DEFICIENCIES PREVIDERS PLAN OF CORRECTION Condent Control Control PREVIDER SPLAN OF CORRECTION BUMMARY STREEMENT OF DEFICIENCIES PREVIDERS PLAN OF CORRECTION Condent Control PREVIDER SPLAN OF CORRECTION BUMMARY STREEMENT OF DEFICIENCIES PREVIDENT SPLAN OF CORRECTION Condent Control PREVIDENT SPLAN OF VAILS BE PLAN OF DEFICIENCIES F000 NINTIAL COMMENTS F000 Submission of this Response and Plan of Correction of Control Contrecontrol Control OF Control Control Contrecontrol Control C	STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
COLDEN LIVINGCENTER - HOPKINS COLDEN LIVINGCENTER - HOPKINS COLDEN LIVINGCENTER - HOPKINS COLDEN LIVINGCENTER - HOPKINS PREFIX COLDEN LIVINGCENTER - HOPKINS PREFIX 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 racelip of an acceptable POC an on-sile revisit of your racelity will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 176 433.010(n) RESIDENT SELF-ADMINISTER SS=D DRUGS IF DEEMED SAFE F 176 An individual resident may self-administer drugs if the interdisoplinany team, as defined by \$433.20(d)(2)(i), has determined that this practice is sale. This REOULREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (M12 and your as a condition of any appeal with may be filed solely because of the regulation of a marked bights were of an acceptable POC and the lights were of an acceptable POC an on-sile review, the facility failed to ensure 2 of 2 residents (M12 and M12 an			245293	B. WING	i		12/	19/2014
PHEEN TAS PHEEN ENDIMARCH SUPERCENSION PHEEN TAS PHEEN TAS CASE-MARGEMEND & CONSTRUCT PHEEN TAS PHEEN ENDIMARCH SUPERCENSION PHEEN TAS CASE-MARGEMEND & CONSTRUCT CONSTRUCT & CONSTRUCT 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. F 000 Submission of fault by the facility, the Executive Direction of any kind by the facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 000 Submission of fault by the facility, the Executive Direction of any kind by the facility of the truth of any facts alleged or the correctiones of any conclusions set forth in the allegations. F 176 483.10(n) RESIDENT SELF-ADMINISTER SS=D F 176 Health 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 (F128, F124) was safe to self-administer medications. Accordingly, the Facility has prepared and submission of a Plan of Correction is submitted as the review met adultation programs. This Plan of correction is submitted as the review as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the review as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the reventive as indication is an appling the creamet to the			OPKINS	1	72	5 SECOND AVENUE SOUTH		
 The facility's plan of correction (POC) will serve as your allegation 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 a admission of the first page of the CMS-2667 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 176 483.10(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 7.222 a.m. The door was wide open and the lights were off. R128 was lying on his back. Ar 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 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 176 SS=D	The facility's plan as your allegation of Department's acce bottom of the first p be used as verifica Upon receipt of an revisit of your facilit that substantial cor has been attained verification. 483.10(n) RESIDE DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), h practice is safe. This REQUIREME by: Based on observa review, the facility f (R128, R124) was medications. Findings include: R128's room was of a.m. The door was off. R128 was lying - At 7:54 a.m. obse opened the bedsid size amount of Ket a range of fungal s cream to the reside	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site ty will be conducted to validate mpliance with the regulations in accordance with your NT SELF-ADMINISTER ED SAFE ent may self-administer drugs if <i>t</i> team, as defined by as determined that this NT is not met as evidenced tion, interview, and document ailed to ensure 2 of 2 residents safe to self-administer observed on 12/17/14, at 7:22 wide open and the lights were on his back. erved nursing assistant (NA)-C e drawer and obtained pea oconazole cream (used to treat kin infections) and applied the ent's back. When NA-C opened	Uncerted I->>+		Submission of this Response and of correction is not a legal admit that a deficiency exists or that Statement of Deficiency was corr cited, and is also not to be constru- an admission of fault by the facility Executive Director or any emplo- agents or other individuals who dra may be discussed in the Response Plan of Correction. In add preparation and submission of this of Correction does not constitut admission or agreement of any kin the facility of the truth of any alleged or the correctness of conclusions set forth in the allegation Accordingly, the Facility has preparate and submitted this Plan of Corre- prior to the resolution of any any which may be filed solely becau- the requirements under state and fel law that mandate submission of a of Correction within ten (10) days of survey as a condition to participa Title 18 and Title 19 programs. Plan of correction is submitted at facting credible allegation comp ECCEIVEI JAN 20 2015	ssion this rectly ed as y, the yees, aft or e and ition, Plan te an d by facts any ons. pared or peal se of cderal Plan of the it in This s the of	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 12/19/2014 245293 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 176 F 176 F 176 Continued From page 1 the drawer there was medications that were * All medications have been removed observed to be stored in the drawer. from the rooms of R128 and R124. - At 7:57 a.m. the observed medications in the Assessments have been completed for drawer included Ketoconazole 1% shampoo, R128 and R124 pertaining to the safety Ketoconazole cream 2%. Nystatin cream (used to in their ability to self administer treat fungal infections) 100,000 units, Albuterol Self administration of inhaler (breathing medication) and budesonide medications. medications will not occur for R128 and inhaler (breathing medication). In addition, both inhalers were noted to have a different name on R124. Medications will not be stored in them which were not R128's. R128 was not able to converse at the time of observation. resident rooms unless the resident has been assessed to be safe in the self The Cognitive loss/dementia Care Area administration of medications. Then Assessment (CAAs) dated 9/17/14, identified those medications will be kept in safe R128 had Alzheimer's and dementia. R128 was storage in the resident's room. also hard of hearing which could impact his All licensed nursing staff have been cognition and cares. The CAA directed staff to re-educated on the requirement that all continue to provide for his needs. residents must be properly assessed to self administer medications. If The physician Order Summary Report dated medications are to be self administered 11/3/14, revealed the Ketoconazole shampoo and by the residents those medications need cream were ordered on 9/6/14. There was no evidence R128 had an order for the inhalers. to be under safe storage in the resident's room. R128's Self-Medication Administration care plan Monitoring to ensure compliance dated 12/16/14, indicated the R128 would safely will be conducted through random administer medications. The care plan directed audits of resident rooms to ensure staff to store medications in a secure location and medications are not present in resident there would be a periodic safety rooms unless the resident has been assessment/evaluation of R128's ability to assessed to safely administer the administer medications. medications and the medications are safely stored. Assessment of Self-Administration of Medications The facility QAPI committee will * dated 12/16/14, indicated R128 able to review the resident room medication self-administer medications with setup by further Nurse/trained medication aide (TMA) and nursing quarterly for audits recommendations. was responsible for storage and for documentation. The date of completion will be 1-28-15. If continuation sheet Page 2 of 53 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 36LS11 Facility ID: 00872

PRINTED: 01/06/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245293 B. WING 12/19/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 176 Continued From page 2 F 176 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.

Facility ID: 00872

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

PRINTED: 01/06/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIP	LE CONSTRUCTION		E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	B	СОМ	IPLETED
		245293	B. WING	i		12/	19/2014
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE RIATE	COMPLETION DATE
F 176	Continued From pa	ige 3	F	176	5		
	dated 12/01 throug update was entered addition of the eye list. The MAR upda Solution [Carboxym 2 drops in both eye EYES OK PER EYE AND KEEP AT BEE On 12/19/14, at 8:5 were expected to cl residents brought in residents brought in residents and discu to obtain proper ord assess residents fo of medications; and medications. The facility Medicat and General Guidel Medications policy of November 2011) din residents' high level who desire to self-a permitted to do so in team has determine safe for the residen facility and there is self-administer." Pro- desires to self-admini- assessment is cond	2 a.m. the DON stated staff heck medications that n to the facility, interview less the medications; staff were ders for all medications; r safety in self-administration densure in safe keeping for ion Administration-Preparation lines Self-Administration of dated 2006, (Revised rected "in order to maintain the l of independence, residents idminister medications are f the facility's interdisciplinary ed that the practice would be t and other residents of the a prescriber's order to pocedures A. If the resident inister medications, an ducted by the interdisciplinary					
	orientation to time),	t's cognitive (including physical, and visual ability to					
	planning process." I	nsibility during the care F. "Bedside medication					
	storage is permitted	I only when it does not present esidents who wander into the					

Event ID:36LS11 Facility ID: 00872

If continuation sheet Page 4 of 53

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

					E CONSTRUCTION	(X3) DATE	E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		245293	B. WING			12/1	19/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH OPKINS, MN 55343		
				п	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 176 F 241 SS=E	rooms of, or room v self-administer. Co BEDSIDE MEDICA bedside storage to 483.15(a) DIGNITY INDIVIDUALITY The facility must pr manner and in an e enhances each res full recognition of h This REQUIREMEN by: Based on observat review, the facility of treatments were im (R165, R85) observ one resident (R73) administration throu In addition, the facili a choice of condim- potential to effect a unit. Findings include: R165 On 12/17/14, at 8:4 the 1 East dining ro with two other resid Nursing assistant (I on R165's left side was no verbal cueir communication obs R165, aside from th	with, residents who nditions outlined in 4.3: TION STORAGE are met for		241	* The resident, R165, will re- respectful and dignified care a times. Staff will converse with during meals and will explain care procedures to R165 b implementation. The resident, will receive respectful and dig care at all times. Staff will know room door before entering and wi allow R85 excessive wait time meals and will explain cares	at all R165 s and before R85 mified ck on ll not e for and before R73, mified cplain before siding ll the n the	

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Facility ID: 00872

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 245293 B. WING 12/19/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) All residents residing in the facility F 241 F 241 Continued From page 5 will receive respectful and dignified from R165's table enough to have heard any care at all times. Staff will knock on regular tone of conversation such as that from another resident at the same table, R125, who doors before entering resident rooms, staff will explain cares and procedures told NA-D about wanting to go back to room but NA-D did not say a word, nodded his head, and before commencing, and staff will continued to feed R165. In addition, R165 was converse with residents during cares. observed for at least three times having spilled Residents will not have excessive wait food from mouth down to clothing protector, as times for meals. All dining areas in the was observed to only take small bites from the will have the necessary facility spoon full of food being fed by NA-D. For each condiments placed on the tables at each time that food were being spilled from R165's meal for consumption. mouth, NA-D used R165's clothing protector to All nursing staff have been rewipe the corners of R165's mouth and chin. educated on the requirement that -At 8:55 a.m. NA-D stood up and continued to residents must receive respectful and feed R165. NA-D was feeding R165 with dignified care at all times. Staff have thickened liquid contained in a plastic cup while been educated to knock on doors before he remained standing on R165's left side. The to explain cares and two plastic cups on R165's table were observed entering. to be empty, while there were two bowls with procedures before implementation, and about 75% of unfinished food in each. to converse with residents during cares. -At 8:58 a.m. NA-D wiped R165's mouth with the Staff have been educated on the clothing protector, took the clothing protector off requirement that residents will not have R165's neck, put it on the table, and then moved excessive wait times for meals. All R165's wheelchair. NA-D never spoke to R165 dietary staff have been educated on the before or while doing all these actions. requirement to have fully stocked -At 9:00 a.m. NA-D went on to push R165's condiment containers on all resident wheelchair out from the dining room to the tables for all meals. hallway and to R165's room. NA-D pushed R165 Monitoring to ensure compliance in wheelchair inside the room towards R165's will be conducted through random bed; the room door was left open. NA-D resident care audits encompassing positioned R165's wheelchair to face door, then observation of dignified resident care. locked the wheelchair brakes. NA-D placed call button on R165's lap then left the room, still Dining room observational audits will without talking to R165. also be conducted to ensure excessive -At 9:04 a.m. R165 looked towards the door when wait time for meals is not present and surveyor knocked and signified to enter room. condiment containers are in proper use R165 was able to maintain eye contact when at every meal. greeted. R165 nodded to agree when surveyor asked to verify that NA-D never talked all through Facility ID: 00872 If continuation sheet Page 6 of 53 Event ID: 36LS11 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/19/2014 B. WING 245293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The facility QAPI committee will F 241 Continued From page 6 F 241 review the dignity resident care audits the time NA-D was with R165 from the dining and the dining room observational room to R165's bedroom and until NA-D left the further audits quarterly for room. However, when surveyor re-phrased question to ask if NA-D talked or explained what recommendations. The date of completion will be 1-28he was doing, R165 just stared at surveyor then moved head to look at the television show on 15. 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

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

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245293	B. WING			12 /*	19/2014
	PROVIDER OR SUPPLIER	DPKINS		7	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	indicated R165 was 12/3/14.	n Record revised 12/3/14, s enrolled for palliative care on	F 2	241			
	change in status da did not speak word make self-understo The MDS identified term memory loss. was totally depende	ata Set (MDS) for significant ated 12/10/14, indicated R165 s, and rarely had the ability to od nor to understand others. R165 to have long and short The MDS also indicated R165 ent on staff for all activities of include transfers, mobility and					
	understood English added R165 would something. NA-D d observations that h explanations regard he was with R165 in until he took R165 I NA-D did not deny	1 p.m. NA-D stated R165 but "would take time." NA-D nod if was in agreement with id not deny surveyor's e did not give any ding his actions during the time n the dining room for breakfast back to room and until he left. that he was standing beside inued to feed R165 with			·		
	open. R85 was obs beside bed, with ey quiet. -At 7:44 a.m., a NA knocking on door, a saying a word, start brakes. NA-A called R85's hand but R85 NA-A pushed R85's	1 a.m. R85 room door was erved sitting in wheelchair es closed. The room was -A entered R85's room without approached R85, then without ted to unlock R85's wheelchair d R85's name once, touched 5's eyes remained closed. s wheelchair from room to 2 East dining room, stopped					

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Facility ID: 00872

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER		I	72	REET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	without talking to R -At 7:52 a.m. R85 r on the same spot w wheelchair. R85's e was alone at table. residents in the din present. -At 8:07 a.m. a diet working in the mini- closed. R85 was we protector. -At 8:19 a.m. R85 h wheelchair's head r was served at R85' -At 8:31 a.m. R85 w spot in the dining ro closed. -At 8:37 a.m. R85 s dining table. A glass juice were observer -At 8:42 a.m. a NA- breakfast plate to F providing R85 with and was talking to F R85's electronic Ad indicated R85 had of Alzheimer's disease The care plan initia had cognitive loss a making capabilities issues. The care pl environmental cues The care plan also remain comfortable care plan further din	wheelchair brakes then left R85 85. emained seated in wheelchair where NA-A had parked the eyes remained closed. R85 There were four other ing room but no staff was ary staff was observed -kitchen. R85's eyes were still earing a green clothing mad leaned head towards rest, with eyes closed. No food	F	241			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:36LS11		Facil	lity ID: 00872 If continua	tion shee	t Page 9 of 53

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	DPKINS		7	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From pa living and staff were doing during cares meals. R73 On 12/18/14, at 7:2 (LPN)-E was obser medication adminis -R73 was lying in b elevated about 10 t feeding was observ contained approxim feeding formula atta LPN-E did not corre the right position fo explain what he wa -Without saying a w the tube feeding the g-tube connection s -LPN-E administere R73's g-tube withou paused to check he during the whole m procedure. R73's e doing. -After the medicatio R73's g-tube, LPN- tube and turned it o R73 that he was do placed the call light then stepped out of R73's current care	Ige 9 e to tell R85 what they were and when assisting with control of the process of stration through g-tube to R73. ed with the head of bed o15 degrees. An ongoing tube yed, with a bottle that hately 50 milliliters (ml) of ached to R73 through g-tube. ect nor made sure R73 was in r tube feeding. LPN-E did not s going to do to R73. word to R73, LPN-E turned off en disconnected it from the site. ed the medications through ut talking to R73. LPN-E never ow R73 felt. R73 was quiet edication administration yes followed what LPN-E was ons were administered via E re-connected the feeding on. LPN-E did not verbalize to one giving medication. LPN-E on top of R73's abdomen, the room. plan initiated on 4/3/13,	F 2				
	potential for abuse cognition, inability to care and decreased plan directed staff t	ety was at risk and had related to decreased o communicate, need for total d physical ability. The care o explain actions before doing n environment to help keep					Page 10 of 53

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY 725 SECOND AVENUE HOPKINS, MN 5534	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	On 12/19/14, at 8:5 (DON) stated it was treat residents with The facility's Social Procedures Manua Subject: SS-702 Di 10/09, indicated all respect and dignity resident's self-worth psychosocial well-b policy directed staff friendly and patient resident as an indiv addition, the policy residents' private sp On 12/16/14, at 8:3 were no evidence of the tables, and ther or pepper packets I also no sugar pack - At 8:35 a.m. NA-0 and stated they we salt or pepper. Duri was no observation asking residents if t pepper. The tables on the tables. Resid their eggs without s - At 8:45 a.m. Cook of nursing (ADON) pepper packets in t would need to ask salt and pepper sha but residents would	 at was going on around. 2 a.m. the director of nursing sher expectation for staff to dignity at all times. Services Policies and I, Section 7: Residents' Rights, gnity dated as revised on residents will be treated with so as to enhance each n and improve his/her being and quality of life. The to speak to residents in a manner, and to focus on the ridual when talking to them. In directed staff to respect bace and property. 0 a.m. at breakfast, there of salt or pepper shakers on re was no evidence of any salt having been used. There were ets available on the tables. a and NA-H were interviewed re to ask if residents wanted ng the meal observation there of staff in the dining room they wanted salt and/or were void of empty packets dents were observed eating 	F 2	241			
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID:36LS11		Facility ID: 00872	If continuati	on sheet	Page 11 of 53

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION		E SURVEY PLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS		72	REET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=D	them out anymore. resident were able On 12/17/14, at 7:4 dining room were of plastic bags of salt for the staff to offer were not afforded t pepper for the food 483.20(c) QUARTE LEAST EVERY 3 M A facility must asse quarterly review ins and approved by C once every 3 month This REQUIREMEI by: Based on observa review, the facility f re-assessments we residents (R126) re Findings include: On 12/15/14, at 8:0 observed to have a the mattress and th mattress was obse frame. On 12/16/14, at 11 maintenance direct mattress against th measured the gap	They verified that not all to request condiments. 15 a.m. the cupboards in the observed and there large and pepper packets available the residents. The residents he choice of sugar, salt and/or I that was served. ERLY ASSESSMENT AT MONTHS ess a resident using the strument specified by the State MS not less frequently than hs. NT is not met as evidenced tion, interview, and document ailed to ensure comprehensive ere completed for 1 of 3 eviewed for accidents. D7 p.m. R126's bed was a big gap between the edge of he bed's foot board. The rved to be too short for the bed 225 a.m. surveyor asked tor (Other)-B to measure the he bed frame. Other-B between the mattress and the 75 inches and the gap between	F2	241 276 Facil	F 276 * Resident, R126, has had the mareplaced on his bed. The new mare does not allow any gaps betwee mattress and the head and foot be R 126's environment has been ass for any potential hazards documented in the medical record. * All residents will have environment assessed for pot hazards including the mattress as p the documentation completed in post fall scene investigative rep All residents will have the environ assessed for potential hazards inclu- the mattress as part of the quar- resident review assessment in whice resident's risk for falls is evaluated. * Clinical Managers have bee educated on the requirement to ind	ttress n the bards. essed and the ential art of n the ports. ment uding rterly h the n re- clude	Page 12 of 53

24523 B WING 12/19/2014 INMEE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE TAG TREET ADDRESS, CITY, STATE, ZP CODE TAG <td< th=""><th></th><th>OF DEFICIENCIES F CORRECTION</th><th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th><th colspan="2">(X2) MULTIPLE CONSTRUCTION A. BUILDING</th><th></th><th colspan="2">(X3) DATE SURVEY COMPLETED</th></td<>		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
Image: Solution of the second activity of the second activity in the second activity of the second activity and the reductance of the second activity of the second ac			245293	B. WING			12/	/19/2014
PMERT TVG PREFIX Reductory OR LSC.DEPTICYING INFORMATION PREFIX TAG CLACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMMENT DEPTICENCY F 276 Continued From page 12 the mattress and the head board was 2.5 inches. Cher-B confirmed R126's mattress was 7.25 inches shorter than the bed frame. Other-B then placed the gap-filler the was holding to fill the gap on R126's food part. 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 ather ough 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 electronic Admission Record also indicated R126 had been in the same room and bed since admission. • The anual Minimum Data Set (MDS) dated 325/14, indicated R126 had bed and the use of the ill-fitting mattress. • The date of completion will be 1-28- 15. Despite the absence of a comprehensive fall re-assessment, a care plan was initiated on 325/13, to indicate 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 conting matters. Despite the absence of a comprehensive fall re-assessment, a care plan was initiated on 325/13, to indicated R126 had plan turthere described R126 to have poor saf			OPKINS		7	25 SECOND AVENUE SOUTH HOPKINS, MN 55343		
 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 the 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 dementa, uncontrolled diabets, mild cognitive impairment and visual impairment related to diabetes. The electronic 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 no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicated R126 had no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicated R126 had no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicated R126 had no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicate R126 had no falls and was not at risk for falls. The subsequent quarterly MDS dated 9/25/14, indicate R126 had no falls and was not at risk for falls. The 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 duscribed R126 to have decreased physicai ability and increased cognitive impairment. The care plan further described R126 to have poor safety awareness 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:36LS11 Facility ID: 00872 If continuation sheet Page 13 of 53		the mattress and the Other-B confirmed inches shorter than placed the gap-fille on R126's foot part On 12/17/14, at 1:0 placed by Other-B in R126's bed. The m what looked like a w mattress in place. The and the foot board hallway as R126's in the days of survey. The electronic Adminicated R126 was including dementia cognitive impairme related to diabetes. Record also indicate same room and be The annual Minimu 3/25/14, indicated F at risk for falls. The dated 9/25/14, indicated injury and the medi comprehensive re- use of the ill-fitting Despite the absence re-assessment, a co 3/25/13, to indicate to medication use, polyneuropathy. The have decreased phe cognitive impairme described R126 to	The electronic Admission the of a comprehensive fall assessment of the fall and the mattress.			the environmental flazard assessment the post fall scene investigative re and the quarterly resident re assessment. * Monitoring to ensure compl will be conducted through ran audits of post fall scene investig reports and quarterly resident re assessments to ensure environmental hazard evaluation been conducted and documented. * The facility QAPI committee review the fall investigation audit quarterly resident assessment audi further recommendations. * The date of completion will be 15.	ports eview iance adom ation eview the has and ts for 1-28-	Page 13 of 53

OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING **B** WING 12/19/2014 245293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 276 Continued From page 13 F 276 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 F 282 comprehensively assess resident's needs, develop a care plan and follow the care plans for Resident, R165, will receive all residents. respectful and dignified care at all 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 F 282 times. Staff will converse with R165 PERSONS/PER CARE PLAN SS=D during meals and will explain cares and The services provided or arranged by the facility procedures to R165 before must be provided by qualified persons in implementation as per plan of care. accordance with each resident's written plan of The resident, R128, will not have care. medications present in his room. Assessments have been completed for R128 pertaining to ability to self This REQUIREMENT is not met as evidenced medications. Self administer by: administration of medications will not Based on observation, interview and document Care plan reflects occur for R128. review, the facility did not ensure care plan was R128's inability to self administer followed for one of two residents reviewed (R165) medications. reviewed for palliative care. In addition, the facility All residents residing in the facility failed to ensure 1 of 2 residents (R128) care plan will receive respectful and dignified was followed for the safe storage of medication when R128 was identified to self-administer care at all times. Staff will converse medications. with residents during cares and will explain cares and procedures before Findings include: implementation as per plan of care. Medications will not be stored in all R165 was observed on 12/17/14, at 8:45 a.m. in resident rooms unless the resident has the 1 East dining room, seated in wheelchair and been assessed to be safe in the self with two other residents at the dining table. administration of medications. Then Nursing assistant (NA)-D was seated in a chair those medications will be kept in safe on R165's left side and was feeding R165. There storage in the resident's room as per the was no verbal cueing heard or any other form of communication observed between NA-D and plan of care.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	<u>SFOR MEDICARE</u> OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPL	E CONSTRUCTION	(X3) DATE	
	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILD	DING		СОМ	PLETED
		245293	B. WING	ì		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	R165, aside from the full of food to R165 from R165's table of regular tone of com another resident at told NA-D about way NA-D did not say a continued to feed F times during the feed only take so much rest of the food spill to the clothing protector to mouth and chin ead -At 8:55 a.m. NA-D feed R165. NA-D w thickened liquid cor he remained standit two plastic cups on to be empty, while the about 75% of unfini- At 8:58 a.m. NA-D clothing protector, the R165's neck, put it R165's wheelchair. before or while doir -At 9:00 a.m. NA-D wheelchair out from hallway and to R165 in wheelchair inside bed, the room door positioned R165's valor locked the wheelch button on R165's la without talking to R -At 9:04 a.m. R165 surveyor knocked a R165 was able to m	he acts of NA-D giving spoons- . Surveyor was within range enough to have heard any versation such as that from the same table, R125, who anting to go back to room but word, nodded his head, and R165. In addition, for three eding observation, R165 could food from the spoon, so the led over R165's mouth down ector. NA-D used R165's or wipe the corners of R165's or wipe the corners of R165's ch time food spilled. stood up and continued to vas feeding R165 with ntained in a plastic cup while ng on R165's left side. The R165's table were observed there were two bowls with shed food in each. wiped R165's mouth with the ook the clothing protector off on the table, and then moved NA-D never talked to R165 ing all these actions. went on to push R165's in the dining room to the 5's room. NA-D pushed R165 is was left open. NA-D vheelchair to face door, then air brakes. NA-D placed call p then left the room, still	F	282	 All nursing staff have been educated on the requirement residents must receive respectful dignified care at all times. All lic nursing staff have been re-educate the requirement that all residents be properly assessed to self adminedications. If medications are self administered by the residents medications need to be under storage in the resident's room. Monitoring to ensure complwill be conducted through rarresident care audits encompare observation of dignified resident care per the plan of care. Random aud resident rooms will be conducted ensure medications are not preseresident rooms unless the resident safely stored as per the plan of care? The facility QAPI committee review the resident room medications. The date of completion will be 15. 	that l and ensed ed on must nister to be those safe liance ndom ussing are as lits of ed to ent in at has er the s are e will care inther	

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(×	(3) DATE SURVEY COMPLETED	
		245293	B. WING			12/19/2014
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, ST 725 SECOND AVENUE SO HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)	E COMPLETION TE DATE
F 282	verify that NA-D ne NA-D was with R16 R165's bedroom ar However, when sur ask if NA-D talked doing, R165 just sta head to look at the roommate's side. The Diagnosis Info electronic Admissic admitted on 12/20/ dizziness and giddi dementia, depressi agitans also known (characterized by s muscle rigidity and indicated R165 was 12/3/14. The Care Area Ass 9/24/14, indicated F communication, an ability, as would onl	ver talked all through the time 55 from the dining room to nd until NA-D left the room. rveyor re-phrased question to or explained what he was ared at surveyor then moved	F	282		
	to "use simple mea include gestures an CAA also indicated psychosocial well-b	ns of communication" to od communication book. The R165 had problem with eing related to change in d with the diagnoses of				
	indicated R165's sa medical conditions include altered men communicate in En staff to do the follow	e plan, initiated on 12/23/13, ifety was at risk in relation to and clinical manifestations to ital status and limited ability to glish. The care plan directed ving interventions: explain all res before performing them;				sheet Page 16 of 5

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO			E SURVEY PLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS 725 SECOND AVI HOPKINS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	short phrases and a no answers and us verbal reminders w orientation; explain environment; use of pictures as needed and provide with im On 12/17/14, at 1:1 understood English language. NA-F sta was something. NA-F sta was something. NA-F ft nice guy" and neve just have to go "che -At 1:21 p.m. NA-D English but "would would nod if was in NA-D did not deny he did not give any actions during the t dining room for bre to room and until h he did not give any to R165 during the R165. On 12/19/14, at 8:5 (DON) stated it was follow care plans of and explain proced before doing them. The facility's Social Procedures Manua Subject: SS-702 Di	ntation while giving care; use questions which require yes or e gestures as needed; use hich assist patient in what is going on in the communication book or to help with communication; terpreter as needed. 2 p.m. NA-F stated R165 n but could not speak the ated R165 would nod if there 65 agreed with or wanted but head if did not want urther described R165 as "a r called for help so staff would eck every two hours." stated R165 understood take time." NA-D added R165 agreement with something. surveyor's observations that explanations regarding his ime he was with R165 in the akfast until he took R165 back e left. NA-D did not deny that environmental re-orientation time he was observed with	F	282			
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUME		JLTIPLE CONSTRUC			E SURVEY PLETED
		245293	B. WIN	G		12/*	19/2014
	PROVIDER OR SUPPLIER	DPKINS			ESS, CITY, STATE, ZIP CODE AVENUE SOUTH IN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		=IX (EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	respect and dignity, resident's self-worth psychosocial well-b policy directed staff friendly and patient resident as an indiv R128's room was o a.m. The door was off. R128 was lying - At 7:54 a.m. obse open and obtained Ketoconazole crear fungal skin infection the resident's back. drawer there were r observed to be stor - At 7:57 a.m. the oid drawer included Ke Ketoconazole crear treat fungal infection inhaler (breathing m inhaler (breathing m noted to have a differ was not R128's. The Cognitive loss/ 9/17/14, identified F dementia. R128 wa could impact his cog directed staff to com The physician Orde 11/3/14, revealed th cream were ordered evidence R128 had R128's Self-Medica	so as to enhance each of and improve his/her being and quality of life to speak to residents manner, and to focus idual when talking to t bserved on 12/17/14, wide open and the ligh on his back. rved NA-C pull bedsid pea size amount of n (used to treat a rang ns) and applied the creat When NA-C opened medications that were	ch . The in a on the hem. at 7:22 hts were e drawer ge of earm to the n the boo, (used to uterol onide ers were which CAA is needs. ted poo and is no ers. re plan	282			
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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 12/19/2014 245293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 Continued From page 18 F 282 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

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245293	B. WING			19/2014
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, STATE, ZIP COD 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 282 F 322 SS=D	rooms of, or room v self-administer. Co BEDSIDE MEDICA bedside storage to 483.25(g)(2) NG TI RESTORE EATING Based on the comp resident, the facility (1) A resident who alone or with assist tube unless the residemonstrates that unavoidable; and (2) A resident who gastrostomy tube re treatment and serv pneumonia, diarrhe metabolic abnorma ulcers and to restor skills.	with, residents who nditions outlined in 4.3: TION STORAGE are met for occur." REATMENT/SERVICES -	F 2	F 322	g-tube ion and G-tube xplanation g, gastric erence to l universal he facility rition or per g-tube ss proper ositioning, adherence cols and e been re- cedures to of g-tube inistration. sed proper ositioning, adherence	
	review, the facility of precaution was obs gastrostomy tube (ensure gastric resid positioning was imp	tion, interview and document did not ensure universal served for the care of g-tube); and facility did not dual was checked and proper olemented during feeding and administration via g-tube for 1		universal precautions. * Monitoring to ensure of will be conducted through observational audits of licen	ompliance n random sed nurses nedication	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			CON	IPLETED
		245293	B. WING				/19/2014
	PROVIDER OR SUPPLIER	OPKINS		725	EET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE SOUTH PKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 322	of 1 resident (R73) administration throu Findings include: On 12/18/14, at 7:2 observed regarding administration throu following: R73 was observed bed elevated about tube feeding was o contained approxim feeding formula att Licensed practical nor made sure R73 tube feeding. LPN-E turned off the disconnected tube site. LPN-E did not LPN-E placed the of R73's undraped ab the disconnected tu- was on the pole. LPN-E took syringe water from water be back to water conta to check g-tube pla small white towel fr up the open end of abdominal area, dra with the towel, then to the g-tube.	observed for medication	FS	322	* The facility QAPI comm review the resident room n audits quarterly for recommendations. * The date of completion v 28-15.	nedication further	
		en he realized having to		-	ID: 00872 If contin	uation sheet	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		245293	B. WING			2/19/2014
	PROVIDER OR SUPPLIER	DPKINS		STREET ADDRESS, CITY, ST 725 SECOND AVENUE SO HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 322	measure air first. Li clamp the g-tube. L of air then re-conne LPN-E injected the gastric area with the LPN-E did not pull k LPN-E disconnecte from the g-tube with placed the open en abdominal area, the pulled the plunger of re-connected syringe The nurse manage while LPN-E was te flush g-tube first with picked up water bot water in the syringe clamping the tube b who then coached h first and also to first flushing. LPN-C ins LPN-C went out to which LPN-E then u flushing. After all the due me water flushes in bet the end, LPN-E re-c and turned the feed talk to R73 during the medication adminis was feeling. LPN-E done giving medica light on R73's abdo was done, and step water bottle which s	PN-E did not pinch off or PN-E measured about 15 ml acted the syringe to the g-tube. air while listening on the e use of his stethoscope. back to check gastric residual. d the piston syringe again nout pinching off the g-tube, d on the towel-draped en holding the syringe, he but from the barrel, then ge barrel to g-tube. r, LPN-C entered the room elling surveyor that he was to the 30 ml of water. LPN-E ttle and was about to pour e without pinching off or but was stopped by LPN-C LPN-E to pinch off the tube t measure 30 ml of water for tructed LPN-E to wait while get a 30 ml medication cup used to measure the water for edications were given, with ween and final 30 ml flush at connected the feeding tube ling pump on. LPN-E did not ne entire procedure of tration, and to check how R73 did not tell R73 that he was tion. LPN-E then placed call minal area, told surveyor he ped out from the room. The still contained water that turned	F3	322		
FORM CMS-25	67(02-99) Previous Versions	dications and the syringe used Obsolete Event ID: 36LS11		Facility ID: 00872	If continuation shee	t Page 22 of 53

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/19/2014 245293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 322 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/19/2014 245293 **B** WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 322 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. 483.25(h) FREE OF ACCIDENT F 323 F 323 F 323 HAZARDS/SUPERVISION/DEVICES SS=E * Appropriate sized mattresses are present for residents R126, R226, R150, The facility must ensure that the resident environment remains as free of accident hazards R148, R136, R28, R87, R224, R72. as is possible; and each resident receives Appropriate sized mattresses are also adequate supervision and assistance devices to present in rooms W113, and E262. prevent accidents. 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. This REQUIREMENT is not met as evidenced All staff have been re-educated on bv: bed safety and the seven entrapment Based on observation, interview, and document zones which could potentially be review, the facility failed to ensure appropriate present placing any resident at risk. sized mattress were in place to prevent accidents Staff have been re-educated on the and injuries for 9 of 122 residents in the facility requirement to notify maintenance (R126, R226, R150, R148, R136, R28, R87, R224, R72). In addition, two unoccupied rooms immediately if a mattress is not were identified in the facility room audit, for ill properly fitting a bed or an entrapment fitting mattresses (W113 and E262). potential is present. Monitoring to ensure compliance Findings include: will be conducted through random bed safety audits to ensure proper sized R126's bed was observed on 12/15/14, at 8:07 p.m. to have a big gap between the edge of the

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
		245293	B. WING		12/19/2014
		DPKINS		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	Ē
				PROVIDER'S PLAN OF CORRE	CTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLE
F 323	mattress and the b was observed to be On 12/16/14, at 11 maintenance direct mattress against th measured the gap foot board to be 4.1 the mattress and th Other-B confirmed inches shorter thar placed the gap-fille on R126's foot part On 12/17/14, at 1:0 placed by Other-B R126's bed. The m what looked like a the mattress and th from the hallway as during the days of R126's current carr indicated R126's sa diagnosis of diabet retinopathy, and in The care plan direct potentially dangerod diagnoses includin diabetes, mild cogr impairment related R226's care plan d for falls and identifit for appropriate size locked/unlocked fo	ed's foot board. The mattress e too short for the bed frame. 25 a.m. surveyor asked for (Other)-B to measure the le bed frame. Other-B between the mattress and the 75 inches and the gap between he head board was 2.5 inches. that R126's mattress was 7.25 the bed frame. Other-B then r he was holding to fill the gap the foot frame. Other-B then r he was holding to fill the gap the foot board was observable s R126's room door was open survey. e plan initiated on 3/25/13, afety was at risk related to es with neuropathy, creased cognitive impairment. er described R126 to have the staff to remove R126 from us situations. R126 had g dementia, uncontrolled nitive impairment and visual		³ mattresses and the abse entrapment zones. * The facility QAPI commi- review the bed safety audits for further recommendations. * The date of completion will 15.	ttee will quarterly

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 12/19/2014 B. WING 245293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 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

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

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	assistance with bed During a facility bed mattress did not fit needed to prevent I was added for safe R148's CAA dated at risk for falls relat medication use. Th indicated insomnia, indicated at risk for the wheelchair for a footrests, locked/ur anti-tipper, but lack bed/mattress for pr 10/28/14, indicated cognitive impairme did not reject cares assessment period transfers and requi During a facility bed mattress did not fit needed to prevent was added for safe R136's care plan da risk for falls and ide wheelchair for appr footrests, locked/ur anti-tipper. The CA history of falls prior falls. R136 was re- a 11/28/14, with admi episodic mood disc per the admission r 11/28/14, indicated	d mobility as needed. d audit it was noted that R150's the bed and a bolster was possible entrapment, a bolster ty. 7/29/14, indicated R148 was ed to balance, wandering and e care plan dated 8/4/14, sleep disturbances, and falls and identified assessing appropriate size, need for nlocked for safety and ed an assessment of the oper fit. The MDS dated a BIMS score of 14/15 (no nt), was mildly depressed and or wander during the . R148 was independent in red cueing for toilet use. d audit it was noted that R148's the bed and a bolster was possible entrapment, a bolster	F	323			Page 27 of 53

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCT			E SURVEY IPLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS			SS, CITY, STATE, ZIP CODE VENUE SOUTH 1 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPH DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	depressed, and ha daily, and rejected the assessment per assistance in trans and used a four-wh ambulate on the ur medical record lack assessment of the During a facility ber mattress did not fit needed to prevent was added for safe R28's MDS dated - and long term men inattention and psy severally depresses wander during the required two perso mobility, one perso use and supervisio room. The care pla risk for falls related cognition, weaknes assessing the when need for footrests, anti-tipper, but lack bed/mattress for pr 12/4/14, at risk for i problems during tra medications. During a facility ber mattress did not fit needed to prevent "temporary" bolster	d verbal behavioral symptoms care one to three days during miod. R136 required limited fers, toilet use, bed mobility heeled rolling walker to hit and in her room. The ked evidence of an mattress on the bed. d audit it was noted that R136's the bed and a bolster was possible entrapment, a bolster ity. 10/2/14, indicated short term hory problems with fluctuating chomotor retardation. R28 was ad and did not reject cares or assessment period. R28 in limited assistance for bed in limited assistance for toilet in for transfers and to walk in in dated 11/22/14, indicated at to use of medication, impaired as and fatigue, and identified elchair for appropriate size, locked/unlocked for safety and ed an assessment of the oper fit. The CAA dated falls related to balance ansition and antipsychotic		323			Page 28 of 53

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245293	B. WING			12/19/2014	
	PROVIDER OR SUPPLIER	245295	D. Milla	STREET ADDRESS, CITY, STATE, ZIP C		12/13/2014	
				725 SECOND AVENUE SOUTH			
GOLDEN	LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 323	R87's annual MDS BIMS of 10/15 (mor R87 was mildly dep cares or wander du R87 required one p bed mobility, toilet u assistance of one s dated 9/22/14, indi dementia and psych plan dated revised related to use of me Parkinson's disease wheelchair for appr footrests, locked/ur anti-tipper, but lack bed/mattress for pr The incident/accide revealed the followi - On 1/16/14, at 100 on the floor next to in bed and slid out. - On 4/19/14, at 5:4 on the floor beside slipped off the edge shoes. - On 4/19/14, at 2:0 floor next to the bed something on the floor R224 was admitted with admission diag disturbance and con Admission Record. (recent admission).	dated 9/9/14, indicated a derate cognitive impairment). pressed and did not reject ring the assessment period. erson extensive assistance for use, and transfers; and limited taff to walk in room. The CAA cated at risk of falls related to hiatric conditions. The care 12/14, indicated at risk of falls edication, dementia and e, and identified assessing the opriate size, need for blocked for safety and ed an assessment of the oper fit. ent reports were reviewed and ng: 00 a.m. R87 was found sitting her bed, stated she had been 1 a.m. R87 was found sitting the bed, stated she had e while trying to reach her 05 a.m. R87 was found on her ed and stated the floor was ried to get into bed. 0 p.m. R87 was found on the d, and stated she was sitting bed and reaching for bor when she slid off the bed. to the facility on 12/13/14, inosis of sleep pattern hvulsions per the electronic A MDS was not available A care plan dated 12/14/14,	F	323			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245293	B. WING		1:	2/19/2014	
	PROVIDER OR SUPPLIER	DPKINS	1	STREET ADDRESS, CITY, STATE, ZIP 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 323	of medication and r plan identified asse appropriate size, ne locked/unlocked fo lacked an assessm proper fit. During a facility bed mattress did not fit needed to prevent "temporary" bolster 12/18/14, at 3:00 p R72's bed was obs p.m. with the Alzhe assistant director o gap was measured mattress to the foo had not been award bed. The ADON ex staff to directly repor problems with the k verified the mattres 12/17/14, at 11:45 a observed at the end and prevent the mat R72 had a significa 4/22/14, and the su indicated R72 was falls and that the fa However, the CAAs mattress as a poten R72's quarterly MD R72 as having two MDS) such as skin	s at risk of falls related to use new environment; the care essing the wheelchair for eed for footrests, r safety and anti-tipper, but tent of the bed/mattress for d audit it was noted that the the bed and a bolster was possible entrapment, a was added for safety. On .m. the mattress was replaced. erved on 12/16/14, at 12:53 imer's director (AD) and the f nursing (ADON). A five inch at the end of the bed from the t board. The AD and the ADON e the mattress did not fit the plained there was a system for ort to maintenance any beds or mattresses. She is had not been reported. On a.m. a bolster cushion was d of the mattress to fill the gap attress from moving. 	F	323			
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		245293	B. WING			2/19/2014
	PROVIDER OR SUPPLIER	DPKINS		STREET ADDRESS, CITY, STATE 725 SECOND AVENUE SOUT HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 323	to have the residen R72's quarterly MD R72 as having two falls with injury (sind tears, abrasions, la hematoma's, and s complain of pain. R as the facility did no as a potential accid The care plan for R indicated R72 was of medication, new dementia, and chro no falls or fall relate included activity pro assessment for pail wheelchair for prop mattress with cut ou intervention on 1/7/ On 12/18/14, at 10: (DON) and director (DES) were intervie patient entrapment where the mattress properly. When ask improvised bolsters added, the DON sta of my head." "We h and had to make so had to order I think were created when and purchased foar "securely taped the bolster for five occut the usual process w	 t complain of pain. S dated 10/22/14, identified falls without injury and two ce the last MDS) such as skin cerations, superficial bruises, prains; or to have the resident 72 was placed at risk for falls ot identify the ill-fitting mattress ent hazard. 72, updated 10/22/14, at risk for falls related to use environment, history of falls, nic anxiety. The goal was for id injuries. Approaches ogramming and exercises, in ever shift, and asses the er fit and safety. A lipped ut was added as and 14. 36 a.m. the director of nursing of environmental services wed regarding potential issues, in the patent rooms es did not fit the beds ed what rooms had a, and what rooms had bolsters ated "I do not know off the top ad some (bolsters) on hand, ome temporary (bolsters) then 10." The temporary bolsters the facility went to the store in swim noodles, cut them and m together" then used as a pied beds. The DES stated when a mattress did not fit a ursing would put a work order 	F3	P23	If continuation shee	et Page 31 of 53

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CENTER	AS FOR MEDICARE	& MEDICAID SERVICES					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>'</i>		PLE CONSTRUCTION		E SURVEY IPLETED
		245293	B. WING	à		12/	19/2014
	PROVIDER OR SUPPLIER	DPKINS	L	-	STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	facilities would put was needed, faciliti The DON added En- computers and kios work order. -The Safety Comm was facilitated by th -Room set up was the admissions dire room for readiness -There was a check ready, but it did not on the bed. -A list of the work o Engines was reque provided). On 12/18/14, at 2:4 Health Care Servic services) stated his for rips or un-clean- report, but do not re- the bed properly. On 12/17/14, at 3:0 Meeting minutes we and did not address way. On 12/17/14, at 3:3 instructions for the inches thick and of [the dimensions are Do not use without bend and conform On 12/18/14, at 10:	lities software program), then in a bolster, or if a lip mattress es would change the mattress. ngines was set up in all sks, so everyone can put in a ittee met once per month, and ne administrator. an interdisciplinary process, ector did the final check of the	F	323	3		

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STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245293	B. WING	-		12/	19/2014
	PROVIDER OR SUPPLIER	240200			TREET ADDRESS, CITY, STATE, ZIP CODE		
					25 SECOND AVENUE SOUTH		
GOLDEN	I LIVINGCENTER - HO	OPKINS		н	OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	bolsters available a flexible foam noodle into three pieces ar pieces into a triang! "temporary bolster." the facility had jerry three occupied bed obtained from an ap health care product On 12/18/14, at 12: together a 7 zones and educated every currently, and will e they arrive. On 12/18/14, at 3:0 mattresses (which i were replaced with obtained from stora On 12/19/14, at 2:0 October of 2014, th incident reports and completed and prov staff on how to do th document on the fo information for anal were we wanted to reduce the number falls." The fall forms (Interdisciplinary Te The Falls Managem directed: *pre-admission inta appropriate fall inter admission	and so purchased round es (swim noodles), cut them nd "securely" taped the three le shape and identified it as a " The DON and DES verified /-rigged a temporary bolster for ls, which had not been pproved manufacturer of ts. 30 p.m. The facility put of entrapment education piece yone working in the facility ducate the evening shift when 00 p.m. all of the ill fitting included W113 and E262) properly fitted mattresses age, and from a sister facility. 00 p.m. the DON stated in the facility had realized that the d fall huddle forms were not vided re-education to the line he post fall huddle and trms for more complete lysis of cause. "Our thoughts get more to the root cause to of falls and eliminate repeat is are reviewed in IDT am) meeting weekly. hent Guideline, dated 6/12/14, ke assessment to assure rventions are in place prior to sessed for fall risk and		323 Fac	Ilty ID: 00872	on sheet I	Page 33 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING **B** WING 12/19/2014 245293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 33 F 323 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, F 334 reported on 24 hour report, IDT team reviewed and makes additional recommendations within 72 * The resident, R28, has been offered hours. the pneumococcal vaccine and has *QAPI (Quality Assurance Performance education regarding the Improvement) committee minutes reflect data received benefits and potential side effects of the analysis..... to identify systemic trends and patterns. pneumococcal immunization. The F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL F 334 medical record for R28 contains the IMMUNIZATIONS SS=D verification that R28 received the immunization or did not receive due to The facility must develop policies and procedures medical contraindication or refusal. that ensure that --All residents residing in the facility (i) Before offering the influenza immunization, have been offered the pneumococcal each resident, or the resident's legal vaccine and have received education representative receives education regarding the regarding the benefits and potential side benefits and potential side effects of the pneumococcal effects of the immunization; immunization. The medical record for (ii) Each resident is offered an influenza all residents contains verification that immunization October 1 through March 31 annually, unless the immunization is medically the resident received the pneumococcal contraindicated or the resident has already been immunization or did not receive due to immunized during this time period; medical contraindication or refusal. (iii) The resident or the resident's legal All licensed nurses have been rerepresentative has the opportunity to refuse educated on the requirement to inform

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FORM APPROVED

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245293	B. WING	à		12/	19/2014
	PROVIDER OR SUPPLIER	DPKINS	L	7	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 334	documentation that following: (A) That the residu- representative was the benefits and po- immunization; and (B) That the residu- influenza immuniza- contraindications o The facility must de- that ensure that (i) Before offering tl immunization, each legal representative the benefits and po- immunization; (ii) Each resident is immunization, unle- medically contrained already been immu- (iii) The resident or representative has immunization; and (iv) The resident or representative was the benefits and po- pneumococcal imm- (B) That the residu- pneumococcal imm-	medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical r refusal. evelop policies and procedures ne pneumococcal resident, or the resident's e receives education regarding tential side effects of the offered a pneumococcal ss the immunization is licated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical	F	334	side effects of the pneumoc vaccine and to record resid immunization or decline immunization on the form provid the medical record. * Monitoring to ensure compl will be conducted through random audits and audits of new admit charts to ensure proper document of immunization status is contain the medical record. * The facility QAPI committee	occal dent's of ed in liance chart ission tation ed in e will audits ons.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	AS FOR MEDICARE				<u> </u>	1	0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245293	B. WING			12/	19/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS			25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	and practitioner rec pneumococcal imm years following the immunization, unle the resident or the refuses the second This REQUIREMEI by: Based on interview facility failed to ens offered and/or rece	e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative l immunization. NT is not met as evidenced v and document review, the ure 1 of 5 residents (R28) was vived pneumococcal commended by Centers for	F 3	334			
	Findings include: The Order Summa 2014, indicated R2	ry Report dated December 1, 8 was admitted to the facility					
	on 11/21/14. Review of R28's im documentation if a had been received, On 12/18/14, at 9:0 (RN)-B, director of control, verified R2 consent on admiss	munization record lacked pneumococcal vaccination , contraindicated or refused. 06 a.m. registered nurse clinical education and infection 8 had not been given a ion for pneumococcal rther indicated she would have					
	expected staff to pr resident if she had	rovide consent and ask received vaccination prior and as to offer resident vaccination					

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STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245293	B. WING		12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS	1	STREET ADDRESS, CITY, STATE, ZIP COI 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 334 F 371 SS=F	On 12/18/14, at 9:4 (HUC) stated she h R28 had been disc records had indicat R28's pneumococc one the hospital ha on the discharge st Golden Clinical Ser and procedure mar October 2011) indic encourage that eac immunization again as a lifetime immun disease. This immu unless it is medical has already been in and/or responsible immunization" 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and	5 a.m. health unit coordinator had called the hospital where harged from and medical ed there was no record of cal immunization and the only d was for influenza as noted ummary. Twices Infection Control policy hual dated 2007 (revised cated "Center will offer and ch resident receive not Influenza annually, as well nization against Pneumococcal unization will be administered ly contraindicated, the resident mmunized or the resident party refuses the ROCURE, /SERVE - SANITARY		 334 371 F 371 * The areas identified the cleaning in the 1 East, 1 We and 2 West kitchenettes have cleaned. This clean encompassed the microware cupboards, drawers, and relocated in these areas. The relocated in these areas. The relation of the second sec	est, 2 East, /e all been ning has ve ovens, efrigerators	
	by: Based on observat review, the facility f	NT is not met as evidenced tion, interview and document ailed to maintain a sanitary nment. This had the potential				
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245293	B. WING		12/19/2014	
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, STATE, ZIP COI 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET	
F 371	Findings include: A tour of the facility was conducted on food service directed dietitian (RD)-A. The made and verified The 1 east serving heavy build-up of d surface. The inside contained consider surfaces of the cup and stains. The 1 west serving soiled on the interior had a large spill of sticky. The FSD ve refrigerator had not The 2 east serving on the outer surface had a build-up of cu of the drawer locate wet. There were pat that were wet and t throughout the drawer The 2 West serving drawers with crume drawers. On 12/15/14, at 12 manual can openent thick and sticky buil	didents in the facility. dining room serving kitchens 12/17/14, at 2:30 p.m. with the or (FSD) and Registered the following observations were by the FSD and RD-A: kitchen microwave oven had a ebris on the interior top of two of four drawers able loose debris. The outside boards were soiled with spills kitchen microwave oven was or surfaces. The refrigerator juice that had dried on and rified the oven and the t been kept up to standards. kitchen cupboards were soled es. Three of four cupboards rumbs and debris. The interior ed under the coffee maker was tokages of coffee in the drawer here was loose coffee grounds	F3	 with a new can opener. * All kitchenette areas in will be cleaned daily to ensumicrowave ovens, cupboards and refrigerators located in the are clean for food storage. opener in the kitchen will be and cleaned daily to procontamination of food. * All dietary staff have educated on the requirement cleaning of the kitchenett facility and the requirement cleaning of the can opener look kitchen. * Monitoring to ensure of will be conducted throug audits of the facility kitcher 	the facility re that the s, drawers, hese areas The can be checked event any e been re- s for daily es in the t for daily cated in the compliance h random enettes for encompass ve ovens, effigerators dom audits nsure daily f the can ained. mittee will henette and arterly for	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS		72	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 371 F 431 SS=E	up of metal shaving expect the can oper verified it was not in A weekly equipmer by the FSD and da inclusion of cleanin policy dated 2011, the dining services sanitation techniqu prevent the outbreat 483.60(b), (d), (e) I LABEL/STORE DF The facility must en a licensed pharmae of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accordar	g. The FSD said he would ener to be cleaned daily and in a sanitary condition. In cleaning schedule provided ted 12/14/14, lacked the indicated it was the policy of department to practice proper es for clean equipment to ak of foodborne illness. DRUG RECORDS, RUGS & BIOLOGICALS Inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted	F 4	431	F 431 * The medications identified in East North medication cart which expired or not properly dated opened have been removed from cart. The medication cart has thoroughly cleaned. The medication which were expired or lacked expiration date have been removed the cart. The medication cart has thoroughly cleaned. The medication which were expired or lacked expiration date have been removed the cart. The medication cart has thoroughly cleaned. The medication which lacked proper expiration da were expired have been removed properly disposed of. The used fer patches for R56 are being disposed documented per policy with licensed nurses signing and without destruction via sewer. All medic	were when m the been ations m cart d the l from the the the the the the the the the the	
	appropriate access instructions, and th applicable. In accordance with	bles, and include the ory and cautionary e expiration date when State and Federal laws, the Il drugs and biologicals in			have been removed from the roo R128. * All medication carts in the fa will be checked and will not car expired medications, or medication properly dated when opened.	acility ontain ns not All	
	locked compartmen controls, and permi have access to the The facility must pr	nts under proper temperature it only authorized personnel to			medications will have expiration All medication rooms in the facilit be checked and expired medication will be removed and dispose properly. All used narcotic medic patches will be properly dispose	y will ations ed of eation	

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STREEM OF DEFICIENCIES (M1 PENDERSUPPLENCY IDENTIFICATION AD PLANOP CORRECTION AD PLANOP CORRECTION TAG (M1 STREET ADDRESS, CHTY, STATE, 2P CODE T2S SECOND AVENUE SOUTH PLANOP CORRECTION TAG (M2 DLANOP CORPETER TAG (M2 PLANOP CORPETER TAG (M2 PLANOP CORPETER TAG (M2 PLANOP CORPETER TAG (M2 PLANOP CORPETER TAG	CENTER	RS FOR MEDICARE	- & MEDICAID SERVICES	_			. 0000 0001
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREE 2P CODE GOLDEN LIVINGCENTER - HOPKINS T23 SECOND AVENUE SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUE SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUE SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUES SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUES SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUES SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUES SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T23 SECOND AVENUES SOUTH IPVID SUMMARY STATEMENT OF DEPICIENCES T24 STREETADDRESS, CITY STATE APPROPRIATE IPVID SUMMARY STATEMENT OF DEPICIENCES T24 STREETADDRESS, CITY STATE APPROPRIATE IPVID SUMMARY STATEMENT AND AVENT A	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1			
GOLDEN LIVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH GOLDEN LIVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH PREFX SUMMARY STATEMENT OF DEFICIENCIES (EACH OBFICIENCY MAST BE PRECIDE OF PULL REGULATIONY OR LSC DERITY IN INFORMATION) 0 F 431 Continued From page 39 controlled drugs listed in Schedule II of the 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. F 431 policy with two licensed nurses signing and witnessing destruction via sever. Medications will be kept in safe storage in 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 som. * All licensed nurses have been re- educated on the requirements to remove expired medications and to adhere to the cleaning schedules for the medication swere stored safely who was identified as beinsure Fentaryl 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 (R122) medications were stored safely who was identified as being able to self-administer their own medications. Z East Unity North-side Medication Cart On 12/18/14, at 1118 a.m. during inspection of the 2 East medication cart, where the following ready to use medication cart, A half-full botte leveremi risufun and an opened bottie of Novolog insulin for R81 which had no labels as to when they were opened. * Monitoring to ensure compliance will be conducted throug weekly audits of medication safe and sanitation of			245293	B. WING		12/	19/2014
Mage with TAG CEACH CORRECT ACT WE ACTION SHOULD BE DEFICIENCY WILL A EXAMPLE TAG CHARCH CORRECTIVE ACTION SHOULD BE DEFICIENCY WILL A EXAMPLE TAG 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 minimat and a missing dose can be readily detected. F 431 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 ensure expired medication earts clean and to adhere to the facility aldel to ensure 1 of 2 residents (R128) medications. F 431 Findings include: Z East Unity 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 medications are to be self administer during the calculation were observed: A half-full bottle of facility supply Tums (medication for hyperacidity) which was expired on 9/10/14, an opened bottle of Novoig insulin for R81 which had on labels as to when they were opened.			OPKINS		725 SECOND AVENUE SOUTH		
 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 that an inssing 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 120 residents. In addition, the facility did not 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 Integrity 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. 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETION
opened. medications and sanitation of		Continued From pa controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr quantity stored is n be readily detected This REQUIREME by: Based on observa review, the facility of medications were of were kept clean. TI 60 out of 120 resid not have a system were accurately de diversion for 1 of 1 facility failed to ens medications were s identified as being own medications. Findings include: 2 East Unit/ North- On 12/18/14, at 11 the 2 East medicat ready to use medic A half-full bottle of (medication for hyp on 9/10/14; an ope and an opened bot	age 39 ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can NT is not met as evidenced tion, interview, and document did not ensure expired discarded; medication carts nis had the potential to affect ents. In addition, the facility did to ensure Fentanyl patches stroyed to prevent potential resident (R56). In addition, the ure 1 of 2 residents (R128) stored safely who was able to self-administer their side Medication Cart 18 a.m. during inspection of ion cart, where the following ation were observed: facility supply Tums peracidity) which was expired ned bottle of Levemir insulin tle of Novolog insulin for R81		policy with two licensed nurses and witnessing destruction via Medications will not be stored resident rooms unless the reside been assessed to be safe in th administration of medications. those medications will be kept storage in the resident's room. * All licensed nurses have be educated on the requirements to respired medications from use, properly date medications when of The licensed nurses have also be educated on the requirement to keen medication carts clean and to add the cleaning schedules for medication carts. The licensed have also been re-educated of protocols to follow for proper d of used narcotic patches an requirement for two nurses to sid destruction via sewer in the narco book. All licensed nursing staff been re-educated on the require that all residents must be pr assessed to self administer medic If medications are to be administered by the residents medications need to be under storage in the resident's room. * Monitoring to ensure comp will be conducted through of audits of medication carts medication rooms to monitor for	sewer. in all int has he self Then in safe een re- eemove and to pened. een re- eep the here to the nurses on the gisposal d the gn off tic log f have rement operly ations. self those r safe	
			s with thick, pink and white		medications and sanitation	of	

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

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION		E SURVEY IPLETED
	245293	B. WING		12/	19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HOPKIN	NS		STREET ADDRESS, CITY, STATE, ZIP COD 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	2	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
the back and sides with approximately 30 bubble On 12/18/14, at 11:36 a.i nurse (LPN)-E verified th medications and medica indicate when they were stated nurses were supp carts at the end of every were charged to make si were kept clean. 2 West Unit/ West-side M On 12/19/14, at 9:39 a.m check the medication ca the following ready to us observed: a bottle of faci (pain reliever and anti-ini 220 milligrams (mg) whic bottle of mineral oil with the had no expiration date; F (pain reliever cream) and wound dressing ointmen and R118's Atropine sulfi- eye and reduces eye dis- which was expired on 11 The middle drawer of the also observed to be dirty	ack. The drawer of pills. In addition, the he medication cart were white powder build-up on multiple pieces of foil and e packages of pills. .m. licensed practical he presence of expired ations with no dates to e opened. LPN-E also bosed to clean medication v shift and night nurses sure medication carts Medication Cart n. LPN-G agreed to art with surveyor, where se medication were sellity supply Naproxen flammatory medication) ch was expired on 8/14; A no name written and also R101's Trixaicin cream d a Silverstat antibacterial nt had no expiration dates; fate (used to dilate the scomfort) 1% solution 1/14. e medication cart was y with white powdery on/treatment bin placed in edication cart was dirty d and greasy substance. d white powders at the ur white loose pills on the	F 4	 medication carts. Random a be conducted of resident ensure medications are not president rooms unless the resident assessed to safely admimedications and the medications and the medication cart/r audits and the reside medication audits quarterly frecommendations. The date of completion will 15. 	rooms to present in sident has nister the titions are hittee will ned room nt room for further	

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Facility ID: 00872

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	_ETED
245293 B. WING 12/19	9/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH HOPKINS, MN 55343 1000000000000000000000000000000000000	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE OF TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OF	(X5) COMPLETION DATE
 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 Alvan (anti-anxiety medication) 2mg/ml which was expired on 8/14; LPN-H placed the liquid Alvan 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 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 to the back was observed an opened box of Fentanyl patches to the back in the facility s policy was not to raise and would get back to surveyor after asking her supervisor. Upon reviewing the narcotic box to the back in spervisor. Upon reviewing the narcotic box in the facility policy was not sure and would get back to surveyor after asking her supervisor. Upon reviewing the narcotic box in the store and vould get back to surveyor after asking her supervisor. Upon reviewing the narcotic box is was observed. In 13/14, 10 12/15/14, R56 had received the Fentanyl patch fourteen times to which only three times tow nurses had documented witnessing the destruction. 	

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Facility ID: 00872

If continuat ag

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		245293	B. WING			12	/19/2014
	PROVIDER OR SUPPLIER	OPKINS		725	REET ADDRESS, CITY, STATE, ZIP COD S SECOND AVENUE SOUTH OPKINS, MN 55343	θE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	two nurses were su the used patch, flus to document in the -At 9:27 a.m. RN-E verified the nurses witnessing the dest potential for diversi facility policy both r narcotic book each On 11/6/14, at 1:42 facility policy for bo immediately in the the destruction. R56's Physician's C R56 had an order f 75 microgram (mos R56's diagnoses in hip joint replaceme traumatic fracture of Record dated 12/12 During review of R8 Administration Rec through 12/18/14, ir Fentanyl patch rem times with only one be determined if the one nurse signed o and applying of the Controlled Substan directed "When a d is removed from the but refused by the f	B approached surveyor stated upposed to witness removing sh it in the toilet and were both narcotic book the destruction. also the unit nurse manager were not documenting truction which increased the on. RN-E further stated it was nurses to document in the time. p.m. DON stated it was the th nurses to document narcotic book upon completing Orders dated 11/5/14, indicated or the Fentanyl patch 72 hour g)/hour (patch used for pain). cluded mylagia and myositis, nt and aftercare for healing of hip obtained from Admission 2/14. 56's Electronic Medication ord (EMAR) dated 12/1/14 t was revealed R56 had the loved and disposed of six nurse signing off. It could not ere were two nurses as only ff for the removal, destruction	F	431			
FORM CMS-25	667(02-99) Previous Versions		1	Facili	ty ID: 00872 If con	tinuation sheet	Page 43 of 53

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	- (>	(3) DATE SURVEY COMPLETED
		245293	B. WING			12/19/2014
	PROVIDER OR SUPPLIER	DPKINS		STREET ADDRESS, CITY, ST 725 SECOND AVENUE SO HOPKINS, MN 55343	ОЛТН	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA ICIENCY)	
F 431	accountability recorrepresenting that do indicate who was re- narcotic books were nurses were consis- patch disposal to pro- R128's room was o a.m. The door was off. R128 was lying - At 7:54 a.m. obser- pull bedside drawer amount of Ketocona- range of fungal skir cream to the reside the drawer there we observed to be stor - At 7:57 a.m. the o drawer included Ke Ketoconazole crear treat fungal infection inhaler (breathing m noted to have a diffi- was not R128's. R1 the time of the obser The Cognitive loss/ Assessment (CAAs R128 had Alzheime also hard of hearing cognition and cares continue to provide The physician Orde 11/3/14, revealed th cream were ordered	sposal is documented on the d/book on the line ose" The policy did not esponsible to oversee the e audited regularly to ensure tently documenting Fentanyl revent potential diversion. bserved on 12/17/14, at 7:22 wide open and the lights were on his back. rved nursing assistant (NA)-C open and obtained pea size azole cream (used to treat a n infections) and applied the nt's back. When NA-C opened ere medications that were ed in the drawer. bserved medications in the toconazole 1% shampoo, n 2%, Nystatin cream (used to ns) 100,000 units, Albuterol nedication). Both inhalers were erent name on them which 28 was unable to converse at ervation. dementia Care Area) dated 9/17/14, identified r's and dementia. R128 was g which could impact his . The CAA directed staff to for his needs. r Summary Report dated e Ketoconazole shampoo and d on 9/6/14. There was no an order for the inhalers.	F 4	31 Facility ID: 00872	If continuation	sheet Page 44 of 53

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

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST			E SURVEY IPLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	DPKINS		725 SECO	DDRESS, CITY, STATE, ZIP CODE IND AVENUE SOUTH 5, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	dated 12/16/14, ind administer medicat staff to store medic there would be a per assessment/evalua administer medicat Assessment of Self dated 12/16/14, ind self-administer medic Nurse/TMA and nur storage and for doc	tion Administration care plan icated the R128 would safely ions. The care plan directed ations in a secure location and eriodic safety tion of R128's ability to ions. -Administration of Medications icated R128 able to dications with setup by rsing was responsible for	F 4	I-31			
	R128 could self-adr stated, "He cannot himself." On 12/18/14, at 8:1 expectation regardi self-administered in	ninister medications. RN-A administer medications 1 a.m. the DON stated her ng storing medications to be a resident's room stated, hould not be in his room."					
	and General Guidel Medications policy of November 2011) dir residents' high leve who desire to self-a permitted to do so it team has determine safe for the residen facility and there is self-administer." Pro- desires to self-admine assessment is cond	ion Administration-Preparation ines Self-Administration of dated 2006, (Revised rected "in order to maintain the el of independence, residents dminister medications are f the facility's interdisciplinary ed that the practice would be t and other residents of the a prescriber's order to occdures A. "If the resident nister medications, an lucted by the interdisciplinary t's cognitive (including		Facility ID: 008	372 If continuati	on sheet	Page 45 of 53

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245293	B. WING			/19/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
GOLDEN	N LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431 F 441 SS=D	carry out this respo planning process." storage is permitted a risk to confused r rooms of, or room v self-administer. Con BEDSIDE MEDICA bedside storage to 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infect (a) Infection Control The facility must es Program under whic (1) Investigates, cor in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre- (1) When the Infecti determines that a re prevent the spread of isolate the resident. (2) The facility must communicable disea	physical, and visual ability to nsibility during the care F. "Bedside medication d only when it does not present esidents who wander into the with, residents who nditions outlined in 4.3: TION STORAGE are met for occur." CONTROL, PREVENT tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction. Program tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, an individual resident; and rd of incidents and corrective fections. ad of Infection on Control Program sident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if	F 4		staff will hing and nen gloves ring the he facility which the to correct of soiled become ovision of been re-	

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Facility ID: 00872

If continuation sheet Page 46 of 53

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION			SURVEY PLETED			
		245293	B. WING			12/1	9/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	DPKINS			25 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	hand washing is inc professional practic (c) Linens Personnel must har transport linens so a infection. This REQUIREMEN by: Based on observat review, the facility d was performed and touching soiled item cares to 1 of 3 resid incontinence. Findings include: On 12/17/14, at 8:4. R89 in the dining ro with assistance. -At 9:16 a.m. observed	AT is not met as evidenced ion, interview and document ide of a document ide of a document ion, interview and document id not ensure handwashing gloves were changed after is during the provision of dents (R89) reviewed for 2 a.m. to 9:15 a.m. observed om (DR) eating her breakfast ved nursing assistant (NA)-A	F 4	441	wash hands prior to the initiation cares, to apply gloves, to rea	nove come wash clean wash care iance care shing uring will for irther	
	stationed R89's whe observed slightly op the room briefly and -At 9:19 a.m. observ opened the door we pulled the curtain th bed and set the call room.	ved NA-A going to room ent to R89's side of room en moved R89 closer to the light on R89's lap and left the					
FORM CMS-25	room then left the ro	was observed going back to com briefly with a clear plastic went into the soiled utility Obsolete Event ID:36LS11		Fa	cility ID: 00872 If continuati	on sheet F	age 47 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
	F CORRECTION		ION NUMBER:	A. BUILDING			CON	PLETED
				A. DOILD				
		24	5293	B. WING			12/	19/2014
NAME OF F	PROVIDER OR SUPPLIER	I		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
					72	5 SECOND AVENUE SOUTH		
GOLDEN	LIVINGCENTER - HO	OPKINS			н	OPKINS, MN 55343		
(X4) ID	SUMMARY STA	TEMENT OF DEFIC	DIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECE	DED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING IN	NFORMATION)	TAG		DEFICIENCY)		
				1				
F 441	Continued From pa	ge 47		F4	141			
	-At 9:38 a.m. obser	ved NA-A goin	g to room with		1			
	the Hoyer lift (mach	nine used for tra	ansferring) and					
	shut the door upon		indicated he					
	was going to lay R8		tata di bassina a					
	-At 9:40 a.m. NA-A							
	going to find anothe down.	er stall to assis	I IIIII IU IAY NOS					
	-At 9:45 a.m. NA-A	returned to roo	om applied the					
	lifting sheet on R89							
	-At 9:50 a.m. NA-B		. Both hooked					
	the lift sheet to the	Hoyer then cor	nmunicated as					
	they both assisted F	R89 off the whe	eelchair to her					
	bed.							
	-At 9:52 a.m. both c							
	-At 9:54 a.m. to 10:							
	undo R89's incontin							
	incontinent then pro							
	the front then as bo							
	the wall R89 started	d to urinate and	d was observed					
	to have stool comin							
	change his gloves a							
	pericare. NA-A was							
	and donned two pai							
	his hands then cont the bottom wiped R							
	movement never re							
	incontinent pad and				ł			
	bedding that was or	n the way and I	R89 exposed					
	lower extremities wi	ith the soiled gl	loves turned					
	her to the door and							
	then went over to th	ie trash can pu	lled the plastic					
	bag with soiled liner							
	then removed the g this time still.	ioves never wa	ashed hands at					
	-At 10:01 a.m. NA-A	was observed	leaving R89's					
	room went to the so							
	as he entered the ro							
	wash his hands betw							
ORM CMS-25	67(02-99) Previous Versions		Event ID: 36LS11		Facil	ity ID: 00872 If continuat	on sheet	Page 48 of 53

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		L. L.	INIR INO	0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245293	B. WING		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - HO	PKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441 F 458 SS=C	after finishing to do was supposed to w acknowledged he h after wiping residen bowel movement. -At 10:04 a.m. licen indicated NA-A was his gloves after peri to wash his hands b "That is an infection" On 12/18/14, at 1:3 expectation on glov registered nurse (R of the facility infectio "staff have been tau must take gloves of reapply new gloves. Handwashing/Hand August 2012, direct their hands for at lea antimicrobial soap a conditions: n. Beford resident with toiletin and water)" 483.70(d)(1)(ii) BED LEAST 80 SQ FT/R Bedrooms must me per resident in multi least 100 square fee This REQUIREMEN by: Based on observati	provide pericare he stated he ash and change gloves. NA-A ad not changed his gloves t bottom after cleaning the sed practical nurse (LPN)-A supposed to have changed care and was also supposed between removing gloves control issue." 1 p.m. When asked what her ing, hand washing was N)-B who also was in charge on control program stated ight when gloves are dirty they f, wash their hands and " Hygiene policy revised ed "Employees must wash ast fifteen (15) seconds using and after assisting a g (hand washing with soup PROOMS MEASURE AT	F 4	 F 458 * Golden Living Center Ho would like to request a waiver F458 in regards to resident room The specific rooms to be includ this waiver are: 140, 141, 142, 143, 146, 163, 165, 167, 169, 171, 173, 222, 224, 240, 258, 260, 262, 264, 271, and 277. * These rooms were construct 1955 and do not meet the curequirements for square footage in bed rooms. There is no meavailable to increase the size or rooms without causing hardship of facility. * Granting this waiver would adversely affect the residents residents 	pkins under size. ed in , 144, 175, 269, ed in urrent two- ethod f the n the l not ng in The nfort, be evel. s or rding r is and	t.

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Facility ID: 00872

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245293 B. WING 12/1 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12/1	19/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN LIVINGCENTER - HOPKINS 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 458 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 administrator stated in the past year, eight double rooms have been converted to private rooms. F 465 * Resident, R102's, room will be kept clean and free from odor. F 465 * Resident, R102's, room will be kept clean and free from odor. F 465 * 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 OAPI committee will review the environmental audits quarterly for further recommendations. * The date of completion will be 1- 28, 15 	

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Facility ID: 00872

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CENTER	AS FOR MEDICARE	E & MEDICAID SERVICES			01		0930-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245293	B. WING		_	12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, STA 725 SECOND AVENUE SOU HOPKINS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD D TO THE APPROPF CIENCY)	BE	(X5) COMPLETION DATE
F 465	one staff with toilet daily living and had On 12/15/14, at 4:5 walking down the h tour a strong musty outside R102's root observed R102 lyin off from the hallway (RN)-A entered the -At 4:52 p.m. the m was not able to smu- for a while and wou be able to pick the -At 4:56 p.m. house approached survey into R102's room b visiting and was as On 12/15/14, at 5:4 manager indicated she was not sure w going into the bathr room. -At 5:44 p.m. obser manager on her kn- wiped all under and -At 5:49 p.m. when strong musty smell administering R102 it was urine smell a suprapubic catheter and thought that wat the room. On 12/15/14, at 7:2 manager stated "Th When asked if she	 use and all other activities of d an indwelling catheter. 50 p.m. as surveyor was hallway during the initial facility y malodorous smell was noted m. Looking inside the room ng in bed and the smell faded y when registered nurse room and shut the door. haintenance director stated he ell as he had been on the floor uld come back maybe he would smell up. ekeeping account manager vor indicated she wanted to go ut at the time R102's wife was sisting R102. 43 p.m. housekeeping account the smell was urine smell and where it was coming from after room and started to clean the roed housekeeping account ees spraying the floor as she d around the bed. asked if he had noticed the 		65			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE						. 0000 0001
	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245293	B. WING	à		12/	19/2014
	PROVIDER OR SUPPLIER	OPKINS		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH IOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 465	stated "Yes" she fur the air vent on the she had sprayed clinoticed a smell con that was where the On 12/16/14, at 9:1 remained to have a staff, residents and observed going pas located down the had acknowledged R10 cleaned. On 12/17/14, at 7:3 room noted still to h was noticeable from room in the hallway at the time and sev including the director maintenance direct administrator. -At 9:22 a.m. surver nurse (LPN)-A went and where the sme stated R102 had a co was where the sme indicated he would see if the strong uri -At 9:30 a.m. both r housekeeping acco room both acknowle when maintenance the room he stated smell from standing hallway. Maintenance and asked what tim	rther stated as she pointed to wall by the bathroom that wher eaning solution she had ning out of it and had thought smell was going from. 10 a.m. to 3:00 p.m. room a strong urine smell. Several I family members were st the room to other rooms allway back and forth. No staff 02's room needed to be 30 a.m. to 9:22 a.m. R102's have a strong urine smell that n standing or walking past the 7. R102's door was wide open reral staff going by the room or of nursing (DON), for and the executive yor and licensed practical t to room when asked what all was coming from LPN-A catheter bag and thought that all was coming from and change the catheter bag to ine smell would fade off. maintenance director and but manager approached the edged the smell was urine and director was asked to enter he was able to smell the urine g outside the room in the ce director further stated "Let e are thinking it's the mattress" usekeeping account manager ite she wanted housekeeping		465			
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:36LS1	1	⊢aci	lity ID: 00872 If continuat	JULI SHEELF	age 52 of 53

STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245293	B. WING			12/	19/2014
	PROVIDER OR SUPPLIER	DPKINS		72	TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH OPKINS, MN 55343		
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	room to be deep cle On 12/18/14, at 8:1 and the executive of smell on 12/17/14, and had started to of be cleaned. When a have reported the s as it was notice DO On 12/19/14, the ho	nursing to get R102 up for the eaned. 6 a.m. the DON stated she lirector had identified the urine but was not sure of the time coordinate for R102's room to asked if she expected staff to mell to housekeeping as soon N stated "Of course." busekeeping policy was not provided instead in-service ed.	F 4		ity ID: 00872	on sheet F	rage 53 of 53

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	5293023	FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245293	B. WING		12/	17/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH		
GOLDEN	LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		
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12-19	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY		JAN 1 6 2015		
EXIT:	Healthcare Fire Insp State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145		MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	q	
	By email to:			TITLE		(X6) DATE
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN		Executive Director		1/13/15

Any deficiency statement ending with an adjerisk (*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED 01/06/2015

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 A. BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245293	B. WING		12/	7/2014
	PROVIDER OR SUPPLIER	DPKINS		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00872

If continuati

PRINTED: 01/06/2015 FORM APPROVED OMB NO: 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION Ng 01 - Main Building 01		E SURVEY IPLETED
	245293	B, WING		12/	17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - H			STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:36LS21

Facility ID: 00872

If continuation sheet Page 3 of 5

PRINTED: 01/06/2015 FORM APPROVED OMB NO: 0938-0391

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
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K 062 K 144 SS=F	Continued From pa on 12/17/2014, rece last documented que conducted on 05/15 This deficient practi- maintenance super inspection. NFPA 101 LIFE SA Generators are insp under load for 30 m accordance with NF Standard for 30 m accordance with NF Based on record re- facility's emergency with NFPA 99 Healt edition) nor NFPA 1 Power Systems (19 practice could affec Findings include: On facility tour betw on 12/17/2014, recor- facility has not cond on their diesel gene reveals that the gen	ge 3 bord review revealed that the parterly fire sprinkler flow was 5/2014. ice was verified by the visor at the time of the FETY CODE STANDARD bected weekly and exercised inutes per month in FPA 99. 3.4.4.1. s not met as evidenced by: eview and interview, the generators do not comply h Care Facilities (1999 10 Standard for Standby 98 edition). This deficient t all residents. even 9:30 AM and 12:45 PM ord review revealed that the ucted annual load bank tests rator. Monthly documentation erator is testing at 25%.	КC	DEFICIENCY) D62 K 144 * A load bank test of the generator will be conducted on with the load bank supplem 30% or greater. * Monthly load bank test facility generator will continuc conducted monthly with the load being recorded. If monthly load being recorded. If monthly load supplementation tests will supplementation tests will supplementation of the load to meet the requirement. * The maintenance staff hat trained on the requirement to I record monthly load bank test facility generator. The main staff have been trained that if load bank supplementation tests conducted with the load being a greater. * Monitoring to ensure conwill be conducted through main audits checking on monthly co of load bank tests with recorded.	facility's 1-21-15 ented to a of the e to be ad bank ad bank ad bank ad bank vill be forward. I require 30% to ve been ave and s of the neave and s of the s of the	
	This deficient praction 67(02-99) Previous Versions	Ce was verified by the Obsolete Event ID:36LS21		for further recommendations. Facility ID: 00872 If cor	tinuation she	et Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245293 12/17/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - HOPKINS** HOPKINS, MN 55343 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 144 Continued From page 4 K 144 The date of completion will be 1-28maintenance supervisor at the time of the 15. inspection. If continuation sheet Page 5 of 5 Facility ID: 00872 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 36LS21

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FORM CMS-2567(02-99) Previous Versions Obsolete

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	The facility has a ca census of 119 at the	pacity of 133 beds and had a time of the survey.			
	The requirement at NOT MET as evider	42 CFR, Subpart 483.70(a) is need by:			

If continuation sheet Page 2 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OF DEFICIENCIES	& MEDICAID SERVICES	(X2: MULT)	PLE CONSTRUCTION (X3) DATE SURVEY
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9.7.5			 A fire sprinkler flow test will conducted on 1-14-15. The fire sprinkler flow tests will sprinkl	
Based on record re has failed to inspec system in accordan	eview and interview, the facility t and maintain the sprinkler ce with NFPA 13 and NFPA		beginning from January 2015 and g forward. * The maintenance staff have trained on the regulation requ quarterly fire sprinkler flow tests	been iring and
Findings include:			sprinkler flow tests.	
on 12/17/2014, reco last documented qu	ord review revealed that the arterly fire sprinkler flow was		will be conducted by the Mainten Director or designee through audi ensure quarterly fire sprinkler flow	ance ts to
maintenance super inspection.	visor at the time of the	K 14	 The facility QAPI committee review the maintenance audits quar for further recommendations. 	terly
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NAME OF PROVID GOLDEN LIVIN	IGCENTER - HO		72	REET ADDRESS CITY, STATE, ZIP CODE 5 SECOND AVENUE SOUTH OPKINS, MN 55343 PROVIDER S PLAN OF CORRECT	
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Base facilit with 1 editic Powe pract Findi On fa on 12 facilit on th revea This o maint	ed on record re ly's emergency NFPA 99 Health on) nor NFPA 1 er Systems (19 ice could affect ngs include: acility tour betw 2/17/2014, reco y has not cond eir diesel genera als that the gen deficient practic	a not met as evidenced by: eview and interview, the generators do not comply in Care Facilities (1999 10 Standard for Standby 98 edition). This deficient t all residents. een 9:30 AM and 12:45 PM and review revealed that the ucted annual load bank tests rator. Monthly documentation erator is testing at 25%. ce was verified by the visor at the time of the		conducted annually going for The annual load bank tests will supplementation of the load to 3 meet the requirement. * The maintenance staff have trained on the requirement to have record monthly load bank tests facility generator. The maint staff have been trained that if m load bank tests are less than 30% load bank supplementation tests r conducted with the load being at a greater.	ted to of the to be d bank d bank d bank d bank ll be orward. require 30% to e been ve and of the enance nonthly annual nust be 30% or
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FORM CMS 2567(02 99) Previous Versions Obsolete

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

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

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

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

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

Golden LivingCenter - Hopkins January 6, 2015 Page 2

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: <u>gloria.derfus@state.mn.us</u> 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,

Are Klegge

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

Enclosures

cc: Original - Facility Licensing and Certification File

Minnesc	ta Department of He	alth			TORMATHOVED
STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	or connection		A. BUILDING		W W BY IF An ten I ten for
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2 000	Initial Comments		2 000		
	·····ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER	· ·		
	144A.10, this correct pursuant to a surve found that the defict herein are not correct not corrected shall I with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with an result in the assess	nether a violation has been	tel Henrich		
	that may result from orders provided that the Department with	nearing on any assessments non-compliance with these a written request is made to in 15 days of receipt of a nt for non-compliance.	R		
lipposete De	Department's staff v the following licensir corrections are com on the bottom of the with "Laboratory Dire Representative's sig	S: b, 2014, surveyors of this isited the above provider and ng orders were issued. When pleted, please sign and date first page in the line marked ector's or Provider/Supplier nature." Make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to Minnesota state statutes/rules for N Homes.	
	partment of Health	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(XG) DATE

LABORATORY DIRECTOR'S OR BROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATI	URE	TITLE	(X6) DATE
les for	Executive	Director	1-13-15
STATE FORM	36LS11		If continuation sheet 1 of 55

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMPI	
		00872	B. WING		12/1	9/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	ND AVENUE , MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of	nether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	Ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
Ainneeste D	Department's staff the following licensi corrections are com on the bottom of the with "Laboratory Dir	"S: 9, 2014, surveyors of this visited the above provider and ng orders were issued. When upleted, please sign and date e first page in the line marked rector's or Provider/Supplier gnature." Make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	ftware. to	

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

TITLE

(X6) DATE

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00872	B. WING		12/19	9/2014
	PROVIDER OR SUPPLIER	OPKINS 725 SEC	DDRESS, CITY, COND AVENU S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	these orders for yo original to the addr Gloria Derfus MDH, Division of H LTC section PO Box 64900 St Paul, MN 55164	lealth Regulation		The assigned tag number appea far left column entitled "ID Prefix The state statute/rule out of com listed in the "Summary Statemen Deficiencies" column and replace Comply" portion of the correction This column also includes the fin which are in violation of the state after the statement, "This Rule is as evidence by." Following the su findings are the Suggested Meth Correction and Time period for C PLEASE DISREGARD THE HEA THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN C CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA S STATUTES/RULES.	Tag." pliance is it of es the "To order. dings statute not met urveyors od of correction. ADING OF H DF S TO Y. THIS TO ION FOR	
2 550	Resident Assessm Subp. 4. Review o home must examir quarterly and must comprehensive ass continued accurac	f assessments. A nursing ne each resident at least revise the resident's sessment to ensure the cy of the assessment.	2 550			
	by: Based on observat	ent is not met as evidenced ion, interview, and document failed to ensure comprehensive	e			

If continuation sheet 2 of 55

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATIO		. ,	E CONSTRUCTION		E SURVEY PLETED
		00872		B. WING		12/	19/2014
IAME OF F	PROVIDER OR SUPPLIER	1	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
OLDEN	LIVINGCENTER - H	OPKINS		OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEI Y MUST BE PRECEDEI LSC IDENTIFYING INFO	NCIES D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 550	Continued From pa	age 2		2 550			
	re-assessments we residents (R126) re						
	Findings include:						
	On 12/15/14, at 8:0 observed to have a the mattress and the mattress was observed frame.	a big gap betweer he bed's foot boar	n the edge of rd. The	ł			
	On 12/16/14, at 11 maintenance direc mattress against th measured the gap foot board to be 4. the mattress and th Other-B confirmed inches shorter than placed the gap-fille on R126's foot par	tor (Other)-B to m be bed frame. Oth between the math 75 inches and the he head board wa R126's mattress in the bed frame. C er he was holding	neasure the ner-B tress and the gap betweer as 2.5 inches. was 7.25 Dther-B then	1			
	On 12/17/14, at 1:0 placed by Other-B R126's bed. The m what looked like a mattress in place. and the foot board hallway as R126's the days of survey.	in R126's bed wa nattress was held wire holder, that h The gap between was observable f room door was op	s no longer ir in place by held the the mattress from the				
	The electronic Adn was admitted on 3 including dementia cognitive impairmer related to diabetes Record also indica same room and be	/22/13, with diagn a, uncontrolled dia ent and visual imp . The electronic A ted R126 had bee	oses betes, mild airment dmission en in the				
	The annual Minimu	um Data Set (MD	S) dated				
TE FOR	epartment of Health M			6899 3	36LS11	lf continua	tion sheet 3 c

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 550	Continued From pa	age 3	2 550			
	at risk for falls. The dated 9/25/14, indi- injury and the med re-assessment of t not comprehensive fall occurrence and mattress. Despite the absend re-assessment, a of 3/25/13, to indicate to medication use, polyneuropathy. Th have decreased ph cognitive impairme described R126 to and impaired judgr	R126 had no falls and was not e subsequent quarterly MDS cated R126 had a fall with no ical lacked a comprehensive the fall. However, R126 was ely re-assessed to include the d the use of the ill-fitting ce of a comprehensive fall care plan was initiated on e R126 was at risk for falls due diagnoses of dementia and ne care plan described R126 to hysical ability and increased ent. The care plan further have poor safety awareness ment. R126's mattress was no ential hazard that could s of a fall.				
	(DON) stated staff comprehensively a	52 a.m. the director of nursing were expected to ssess resident's needs, n and follow the care plans for				
	The Director of Nu develop policies ar assess a residents Director of Nursing educate the approp Director of Nursing develop a system f	esident fall risk function when a	L			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	9			

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SL IDENTIFICATIO			CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER		STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS		OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565				
	Subp. 3. Use. A comust be used by al care of the resident	l personnel invol					
	This MN Requirement by: Based on observation review, the facility of followed for one of reviewed for palliation failed to ensure 1 of was followed for the when R128 was ide medications.	ion, interview an lid not ensure ca two residents re ive care. In addit f 2 residents (R e safe storage o	d document are plan was viewed (R165) ion, the facility 128) care plan f medication	<i>,</i>			
	Findings include:						
	R165 was observed the 1 East dining ro with two other resid Nursing assistant (I on R165's left side was no verbal cuein communication obs R165, aside from th full of food to R165 from R165's table e regular tone of com another resident at told NA-D about wa NA-D did not say a continued to feed F	oom, seated in w lents at the dinin NA)-D was seate and was feeding heard or any served between he acts of NA-D . Surveyor was w enough to have h versation such a the same table, anting to go back word, nodded h	heelchair and g table. ed in a chair g R165. There other form of NA-D and giving spoons- vithin range heard any is that from R125, who a to room but is head, and				

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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 5	2 565			
	to the clothing protector t mouth and chin ea -At 8:55 a.m. NA-D feed R165. NA-D w thickened liquid co he remained stand two plastic cups or to be empty, while about 75% of unfin -At 8:58 a.m. NA-D clothing protector, R165's neck, put it R165's wheelchair before or while doi -At 9:00 a.m. NA-D wheelchair out from hallway and to R16 in wheelchair inside bed, the room door positioned R165's locked the wheelch button on R165's la without talking to F -At 9:04 a.m. R165 surveyor knocked a R165 was able to r greeted. R165 nod verify that NA-D ne NA-D was with R16 R165's bedroom a However, when su ask if NA-D talked doing, R165 just st head to look at the roommate's side.	b looked towards the door when and signified to enter room. maintain eye contact when ded when surveyor asked to ever talked all through the time 65 from the dining room to nd until NA-D left the room. rveyor re-phrased question to or explained what he was ared at surveyor then moved television show on				
		rmation section of R165's on Record indicated R165 was				

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH			
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2 565	Continued From pa	age 6	2 565				
	dizziness and giddi dementia, depress agitans also knowr (characterized by s muscle rigidity and	13, with diagnoses including iness, pneumonia, diabetes, ive disorder, and paralysis n as Parkinson's disease shaking of fingers and hands, shuffling gait). It was further s enrolled for palliative care on					
	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.						
	indicated R165's sa medical conditions include altered mer communicate in Er staff to do the follow procedures and ca provide reality orien short phrases and no answers and us verbal reminders w orientation; explain environment; use of pictures as needed	e plan, initiated on 12/23/13, afety was at risk in relation to and clinical manifestations to ntal status and limited ability to nglish. The care plan directed wing interventions: explain all res before performing them; ntation while giving care; use questions which require yes or se gestures as needed; use <i>t</i> hich assist patient in what is going on in the communication book or to help with communication; terpreter as needed.					
	understood English	I2 p.m. NA-F stated R165 h but could not speak the ated R165 would nod if there					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING		12/19/2014	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		12/13/2014	
		725 SEC	OND AVENUE			
	I LIVINGCENTER - H	HOPKIN	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	R165 would shake something. NA-F funce guy" and never just have to go "chi- -At 1:21 p.m. NA-D English but "would would nod if was in NA-D did not deny he did not give any actions during the dining room for breat to room and until h he did not give any	65 agreed with or wanted but head if did not want urther described R165 as "a er called for help so staff would eck every two hours." 0 stated R165 understood take time." NA-D added R165 n agreement with something. surveyor's observations that r explanations regarding his time he was with R165 in the eakfast until he took R165 back e left. NA-D did not deny that r environmental re-orientation time he was observed with				
	(DON) stated it wa follow care plans o	52 a.m. the director of nursing s her expectation for staff to f residents, for staff to talk to dures and cares to residents				
	Procedures Manua Subject: SS-702 D 10/09, indicated all respect and dignity resident's self-wort psychosocial well-to policy directed staf friendly and patient	I Services Policies and al, Section 7: Residents' Rights ignity dated as revised on residents will be treated with x, so as to enhance each th and improve his/her being and quality of life. The f to speak to residents in a t manner, and to focus on the vidual when talking to them.	,			
		observed on 12/17/14, at 7:22 wide open and the lights were on his back.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	 At 7:54 a.m. observed per and obtained Ketoconazole creatingal skin infectio the resident's back drawer there were observed to be storeat resident's back drawer included Ketoconazole creating and infection inhaler (breathing minhaler (breathing minhaler	erved NA-C pull bedside drawe pea size amount of m (used to treat a range of ns) and applied the cream to . When NA-C opened the medications that were				
	dated 12/16/14, inc administer medical staff to store medic there would be a p	ation of R128's ability to	ł			
	dated 12/16/14, inc self-administer me	f-Administration of Medications licated R128 able to dications with setup by rsing was responsible for cumentation.	3			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
	I LIVINGCENTER - HO	725 SEC	OND AVENUE	SOUTH			
		HOPKINS	6, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	ige 9	2 565				
	(DON) stated her e medications to be s resident's room sta not be in his room." the care plan was r The facility Medicat and General Guide Medications policy November 2011) di residents' high leve who desire to self-a permitted to do so i team has determine safe for the residen facility and there is self-administer." Pr desires to self-adm assessment is cond team of the residen orientation to time), carry out this respo planning process." storage is permitted a risk to confused r rooms of, or room v self-administer. Con BEDSIDE MEDICA bedside storage to SUGGESTED MET DON or designee c procedures or facili care plan and make Appropriate staff co any changes. The I	tion Administration-Preparation lines Self-Administration of dated 2006, (Revised rected "in order to maintain the I of independence, residents administer medications are f the facility's interdisciplinary ed that the practice would be it and other residents of the a prescriber's order to ocedures A. "If the resident inister medications, an ducted by the interdisciplinary it's cognitive (including physical, and visual ability to nsibility during the care F. "Bedside medication d only when it does not present esidents who wander into the with, residents who nditions outlined in 4.3: TION STORAGE are met for					

	ta Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	ESURVEY
	OF CORRECTION	DENTIFICATION NUMBER:				PLETED
		00872	B. WING		12/	19/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	FION SHOULD BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE
2 565	Continued From pa	age 10	2 565			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.	1			
	by: Based on observat review, the facility f sized mattress wer and injuries for 9 of (R126, R226, R150 R224, R72). In add	ent is not met as evidenced ion, interview, and document ailed to ensure appropriate e in place to prevent accidents f 122 residents in the facility 0, R148, R136, R28, R87, lition, two unoccupied rooms ne facility room audit, for ill W113 and E262).				
	Findings include:					
	observed to have a the mattress and the	07 p.m. R126's bed was a big gap between the edge of he bed's foot board. The rved to be too short for the bed	k			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIEF	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
OLDEN	LIVINGCENTER - H	IOPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From p	age 11	2 830				
	frame.						
	maintenance direct mattress against t measured the gap foot board to be 4 the mattress and t Other-B confirmed inches shorter tha placed the gap-fille on R126's foot par	 :25 a.m. surveyor asked ctor (Other)-B to measure the he bed frame. Other-B between the mattress and the .75 inches and the gap between he head board was 2.5 inches. d that R126's mattress was 7.25 n the bed frame. Other-B then er he was holding to fill the gap rt. 01 p.m. the gap-filler that was 	5				
	placed by Other-B R126's bed. The r what looked like a the mattress and t	in R126's bed was no longer ir nattress was held in place by wire holder. The gap between the foot board was observable is R126's room door was open	1				
	indicated R126's s diagnosis of diaber retinopathy, and in The care plan furth poor safety aware The care plan dire potentially danger diagnoses includir	re plan initiated on 3/25/13, safety was at risk related to ites with neuropathy, ncreased cognitive impairment. her described R126 to have ness and impaired judgment. iccted staff to remove R126 from ous situations. R126 had ing dementia, uncontrolled unitive impairment and visual d to diabetes.					
	for falls and identif for appropriate siz locked/unlocked for lacked an assess proper fit. The Can	dated 12/5/14, indicated at risk fied assessing the wheelchair e, need for footrests, or safety and anti-tipper, but ment of the bed/mattress for re Area Assessment (CAA) dicated risk of falls related to					

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00872	_	B. WING		12/19/2014	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		10/2011	
		725 SF					
OLDEN	I LIVINGCENTER - H	HOPKINS HOPKI	NS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 12	2 830				
	when first standing medications. The M dated 12/8/14, rever Mental Status (BIM cognitive impairme assistance for seque The facility bed aud did not fit the bed a prevent possible er bolster was added 10:36 a.m. the facil enough bolsters av round flexible foam them into three pie three pieces into a	ig tasks, difficulty stabilizing and antipsychotropic Minimum Data Set (MDS) ealed a Brief Interview for IS) score of 12/15 (mild ent), and required staff uencing of daily activities. dit it was noted the mattress and a bolster was needed to intrapment, a "temporary" for safety. On 12/18/14, at lity stated they did not have vailable and so purchased in noodles (swim noodles), cur ces and "securely" taped the triangle shape and identified olster." On 12/18/14, at 3:00 was replaced.					
	score of 7/15 (sever moderately depress three days during the required extensive mobility and toilet us staff for transfers, a room. The CAA data moves from a flat a and socializing, and assist with transfer safety. R150's care identified at risk for the wheelchair for a footrests, locked/un	11/6/14, indicated a BIMS are cognitive impairment), wa sed and rejected cares one t he assessment period. R150 assist of two staff for bed use, and limited assist of one and supervision to walk in the ted 11/7/14, indicated R150 affect and isolating to smiling d her daily needs vary. Staff s and mobility to maintain e plan dated 11/27/14, falls and identified assessing appropriate size, need for nlocked for safety and ted an assessment of the	D				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE IS, MN 55343	SOUTH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	i.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 13	2 830			
		the bed and a bolster was possible entrapment, a bolster ty.	r			
	at risk for falls relat medication use. The indicated insomnia, indicated at risk for the wheelchair for a footrests, locked/ur anti-tipper, but lack bed/mattress for pr 10/28/14, indicated cognitive impairment did not reject cares assessment period transfers and requi	7/29/14, indicated R148 was ed to balance, wandering and e care plan dated 8/4/14, sleep disturbances, and falls and identified assessing appropriate size, need for hlocked for safety and ed an assessment of the oper fit. The MDS dated a BIMS score of 14/15 (no nt), was mildly depressed and or wander during the . R148 was independent in red cueing for toilet use. d audit it was noted that R148' the bed and a bolster was	s			
	was added for safe R136's care plan da risk for falls and ide	possible entrapment, a bolster ty ated 10/28/14, indicated at entified assessing the opriate size, need for	r			
	anti-tipper. The CA history of falls prior falls. R136 was re-a 11/28/14, with adm	Nocked for safety and A dated 10/30/14, indicated a to admission and at risk of admitted to the facility on ission diagnosis of depression order and generalized anxiety				
	per the admission r 11/28/14, indicated cognitive impairme	ecord. A discharge MDS date a BIMS score of 13/15 (no nt), was moderately				
	daily, and rejected the assessment pe	d verbal behavioral symptoms care one to three days during riod. R136 required limited fers, toilet use, bed mobility				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED - 12/19/2014	
		00872	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	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.					
			E			
	mattress did not fit needed to prevent "temporary" bolster 12/18/14, at 3:00 p R87	d audit it was noted that the the bed and a bolster was possible entrapment, a r was added for safety. On .m. the mattress was replaced dated 9/9/14, indicated a				
	BIMS of 10/15 (mo R87 was mildly dep	derate cognitive impairment). pressed and did not reject uring the assessment period.				

	ota Department of He		T			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HO)PKINS	OND AVENUE 5, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	R87 required one p bed mobility, toilet u assistance of one s dated 9/22/14, indi dementia and psych plan dated revised related to use of me Parkinson's disease wheelchair for appr footrests, locked/ur anti-tipper, but lack bed/mattress for pro The incident/accide revealed the followi - On 1/16/14, at 10: on the floor next to in bed and slid out. - On 4/19/14, at 5:4 on the floor beside slipped off the edge shoes. - On 4/19/14, at 10: knees next to the b slippery when she t - On 10/5/14, at 2:0 floor next to the beside	erson extensive assistance for use, and transfers; and limited taff to walk in room. The CAA cated at risk of falls related to hiatric conditions. The care 12/14, indicated at risk of falls edication, dementia and e, and identified assessing the opriate size, need for flocked for safety and ed an assessment of the oper fit. ont reports were reviewed and ng: 00 a.m. R87 was found sitting her bed, stated she had been 1 a.m. R87 was found sitting the bed, stated she had e while trying to reach her 05 a.m. R87 was found on her ed and stated the floor was				
	R224 R224 Was admitted with admission diag disturbance and co available (recent ac 12/14/14, indicated related to use of me environment; the ca the wheelchair for a	oor when she slid off the bed. d to the facility on 12/13/14, gnosis of sleep pattern nvulsions. A MDS was not lmission). A care plan dated R224 was at risk of falls edication and new are plan identified assessing appropriate size, need for locked for safety and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING	B. WING		12/19/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	· · · · ·		
OLDEN	I LIVINGCENTER - H	OPKINS	COND AVENUE NS, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 16	2 830				
	anti-tipper, but lack bed/mattress for pr	ed an assessment of the roper fit.					
	mattress did not fit needed to prevent "temporary" bolster	d audit it was noted that the the bed and a bolster was possible entrapment, a r was added for safety. On .m. the mattress was replace	d.				
	observed with the A the assistant direct gap was measured mattress to the foo had not been awar bed. The ADON ex staff to directly repor- problems with the A verified the mattress 12/17/14, at 11:45 observed at the en	:53 p.m. R72's bed was Alzheimer's director (AD) and for of nursing (ADON). A 5 inc d at the end of the bed from th t board. The AD and the ADO e the mattress did not fit the splained there was a system for ort to maintenance any beds or mattresses. She as had not been reported. On a.m. a bolster cushion was d of the mattress to fill the ga attress from moving.	e N or				
	4/22/14, and the su indicated R72 was falls and that the fa	ant change MDS completed of ubsequent CAA Summary identified as being at risk for acility would care plan the falls s did not identify the the ntial fall risk.					
	R72 as having two MDS) such as skin	OS dated 7/22/14, identified falls with injury (since the last tears, abrasions, lacerations hematoma's, and sprains; or nt complain of pain.	,				
	R72 as having two	DS dated 10/22/14, identified falls without injury and two ce the last MDS) such as skir	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING		12/19/20	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE		10/2011
		725 SEC	OND AVENUE			
JOLDEN	I LIVINGCENTER - H	HOPKINS HOPKIN	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	hematoma's, and s complain of pain. F	cerations, superficial bruises, prains; or to have the resident 72 was placed at risk for falls ot identify the ill-fitting mattress lent hazard.				
	indicated R72 was of medication, new dementia, and chro no falls or fall relate included activity pro assessment for pai wheelchair for prop	872, updated 10/22/14, at risk for falls related to use environment, history of falls, onic anxiety. The goal was for ed injuries. Approaches ogramming and exercises, in ever shift, and asses the per fit and safety. A lipped ut was added as and '14.				
	(DON) and director (DES) were intervie patient entrapment where the mattress properly. When as improvised bolsters added, the DON st of my head." "We h and had to make sc had to order I think were created when and purchased foa "securely taped the bolster for five occu the usual process of bed properly was n into Engines (a fac facilities would put was needed, facilitie The DON added E	36 a.m. the director of nursing of environmental services ewed regarding potential issues, in the patent rooms ses did not fit the beds ked what rooms had s, and what rooms had bolsters ated "I do not know off the top had some (bolsters) on hand, ome temporary (bolsters) then 10." The temporary bolsters the facility went to the store m swim noodles, cut them and em together" then used as a upied beds. The DES stated when a mattress did not fit a ursing would put a work order ilities software program), then in a bolster, or if a lip mattress les would change the mattress ngines was set up in all sks, so everyone can put in a	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00872		B. WING		12/	12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	1	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVINGCENTER - H	OPKINS		OND AVENUE 5, MN 55343	SOUTH			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 18		2 830				
	 The Safety Comm was facilitated by th -Room set up was the admissions dire room for readiness There was a check ready, but it did not on the bed. A list of the work of Engines was request provided). A review of the fact revealed November 2013 - 28 falls, Jan - 17 falls, March - 2 36 falls, June - 39 falls, September - 3 hovember - 24 falls 	he administr an interdisci actor did the k list to ensu t include che order for mat ested from th sility fall totals r 2013 - 29 f nuary 2014 - 28 falls, Apr falls, July - 2 32 falls, Octo s. A total of	ator. plinary process, final check of the re things were cking the mattress tress changes in the DES (but not per month falls, December 19 falls, February il - 30 falls, May - 9 falls, August - 26 ober - 27 falls,					
	A review of the 201 a 59.7% turnover in a 27.4 % turnover in (LPN)/licensed voo 23.6% turnover in 12/19/14, at 9:30 a included all turnove specific to unwante	n nursing as in licensed p ational nurs registered nu .m. the DON er by job clas	sistant (NA)/Aide, ractical nurse e (LVN), and a urse (RN) staff. On I stated the rates					
	A review of the rest of call lights being September 2014, v done to resolve the	answered fo vith no expla	r July, August, and					
	On 12/18/14, at 2:4 Health Care Servic services) stated his for rips or un-clean report, but do not re	es Group (h s staff would able surface	ousekeeping review mattresses s which they					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION		• •			E SURVEY PLETED	
		00872		B. WING		12/	12/19/2014	
IAME OF I	PROVIDER OR SUPPLIER		STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	•		
OLDEN	I LIVINGCENTER - H	OPKINS		OND AVENUE 6, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 19		2 830				
	the bed properly.							
	On 12/17/14, at 3:0 Meeting minutes w and did not addres way.	ere reviewed for th	ree months,					
	On 12/17/14, at 3:3 instructions for the inches thick and of [the dimensions ard Do not use without bend and conform	bed say "a mattree the recommended e not in the hand o a special mattress	ss at least 4 d dimensions ut]. s designed to					
	On 12/18/14, at 10 DON and DES the bolsters available a flexible foam nood into three pieces at pieces into a triang "temporary bolster, the facility had jerry three occupied beco obtained from an a health care produc	facility did not hav and so purchased i es (swim noodles) nd "securely" taped le shape and ident " The DON and Di y-rigged a tempora Is, which had not b pproved manufact	e enough round , cut them d the three tified it as a ES verified ary bolster for been					
	On 12/18/14, at 12 together a 7 zones and educated ever currently, and will e they arrive.	of entrapment edu yone working in th	e facility					
	On 12/18/14, at 3:0 mattresses were re mattresses obtaine sister facility.	placed with prope	rly fitted					
	On 12/19/14, at 2:0 October of 2014, th incident reports and epartment of Health	ne facility had realize	zed that the					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 20	2 830			
	staff on how to do t document on the fo information for ana were we wanted to reduce the number falls." The fall form (Interdisciplinary Te The Falls Manager directed: *pre-admission inta appropriate fall inter admission *new admission as immediate plan of "fall alert" commun *fall risk brochure p *IDT team evaluate *Complete Minimun Assessments and *Following a fall, re nurse and initiates Report - Post Fall/T physician/represen interventions imple *Continue ongoing Intervention Trackin nurse initiates DQI reported on 24 hou and makes addition hours. *QAPI (Quality Ass Improvement) com analysis to iden patterns.	provided to resident/family. es the fall prevention plan. m Data Set and Care Area care plan updated. sident is assessed by licensed the Change In Condition				

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/19/201	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 21	2 830			
	necessary revision Appropriate staff co any changes. The develop a system t	nily preferences and make any s to facility paperwork. ould be educated regarding DON or designee could to monitor staff for compliance R CORRECTION: Twenty-one				
2 930	MN Rule 4658.052 Nasogastric, Gastr	5 Subp. 7 B. Rehab - rostomy tubes	2 930			
	and feeding syringes. Based of	tric tubes, gastrostomy tubes, on the comprehensive resident sing home must ensure that:				
	gastrostomy tube of appropriate treatme aspiration pneumo dehydration, metab	who is fed by a nasogastric or or feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, polic abnormalities, and ulcers and to restore, if eeding function.				
	by: Based on observat review, the facility of precaution was obs gastrostomy tube (ensure gastric resi positioning was im prior to medication	tion, interview and document did not ensure universal served for the care of g-tube); and facility did not dual was checked and proper plemented during feeding and administration via g-tube for observed for medication				

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY PLETED
		00872	B. WING		12/	19/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE	•	
OLDEN	I LIVINGCENTER - H	OPKINS	COND AVENUE IS, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 930	Continued From pa	age 22	2 930			
	Findings include:					
	observed regarding	26 a.m. a series of actions g the process of medication ugh g-tube, included the				
	bed elevated about tube feeding was o contained approxim feeding formula att Licensed practical	to be lying in bed with head o t 10 to 15 degrees. An ongoing observed, with a bottle that nately 50 milliliters (ml) of ached to R73 through g-tube. nurse (LPN)-E did not correct 3 was in the right position for	g			
	disconnected tube site. LPN-E did not LPN-E placed the o R73's undraped ab	ne tube feeding then from the g-tube connection pinch off or clamp the tube. open end of the g-tube on odominal skin area and hanged ube where the formula bottle	E			
	water from water b back to water conta to check g-tube pla small white towel fr up the open end of abdominal area, dr	e from bedside table, aspirated ottle, but pushed water out an ainer when he realized he had acement first. LPN-E took a rom bedside table then picked the g-tube from R73's raped the abdominal skin area an connected the piston syringe	d			
	from the g-tube wh measure air first. L clamp the g-tube. I	nnected the piston syringe en he realized having to PN-E did not pinch off or _PN-E measured about 15 ml ected the syringe to the g-tube				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/	19/2014
	PROVIDER OR SUPPLIER	725 SE	ADDRESS, CITY, ST			
GOLDEN	I LIVINGCENTER - H		NS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 930	Continued From pa	age 23	2 930			
	gastric area with th	air while listening on the e use of his stethoscope. back to check gastric residua	al.			
	from the g-tube wit placed the open en abdominal area, th	ed the piston syringe again hout pinching off the g-tube, ad on the towel-draped en holding the syringe, he out from the barrel, then ge barrel to g-tube.				
	while LPN-E was te flush g-tube first wi picked up water bo water in the syringe clamping the tube I who then coached first and also to first flushing. LPN-C inst LPN-C went out to	er, LPN-C entered the room elling surveyor that he was to th 30 ml of water. LPN-E ttle and was about to pour e without pinching off or but was stopped by LPN-C LPN-E to pinch off the tube at measure 30 ml of water for structed LPN-E to wait while get a 30 ml medication cup used to measure the water for				
	water flushes in be the end, LPN-E re- and turned the feed talk to R73 during t medication adminis was feeling. LPN-E done giving medica light on R73's abdo was done, and step water bottle which a cloudy from the me	edications were given, with tween and final 30 ml flush a connected the feeding tube ding pump on. LPN-E did not the entire procedure of stration, and to check how R7 did not tell R73 that he was ation. LPN-E then placed call ominal area, told surveyor he oped out from the room. The still contained water that turn edications and the syringe use inistration were left at R73's	73 ed			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/	19/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	· · · ·	
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 930	Continued From pa	age 24	2 930			
	include acute respi	11/08, with diagnoses to ratory failure, bleeding of the ct, intestinal infections, and sease.				
	indicated R73 was related to dysphagi Facility staff were d interventions which bed at least 30 to 4 to apply slight press	plan initiated on 10/8/10, dependent on tube feeding a (difficulty swallowing). lirected to implement included elevating head of 5 degrees during feeding and sure to tube feeding syringe edication administration.				
	nurses should not he they were not trained practice for the resi were expected to c residuals, elevate h	30 a.m. LPN-C agreed that be left alone to do procedures ed to do as it would be unsafe idents. LPN-C stated nurses heck g-tube placement, gastri head of bed as tolerated by to residents to check if they				
	(DON) stated nurse proper procedures through the g-tube and placing a drape just leave the open bare abdominal ski	52 a.m. the director of nursing es were expected to follow in medication administration to include aseptic technique e to protect the g-tube and not end lying on top of resident's in. DON also stated emphasis ining procedures before				
	Feeding with last re staff to explain proo the resident in a sit with the head of be during the feeding a	for Administration of Enteral eview dated 11/13/14, directed cedure to the resident; place ting or semi-sitting position, d elevated at least 30 degrees and for at least an hour after placement by injecting 10 to				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO		OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 930	Continued From pa	ige 25	2 930			
	gastric contents; pi so air does not enter syringe run empty of runs empty; rinse the observe the reside SUGGESTED MET DON or designee of procedures or facilit standards of practic administration/care any necessary revis be educated regard designee could dev for compliance.	owly draw back to check nch off g-tube below the port or pinch off g-tube before it ne syringe after use; and ont for signs of discomfort. THOD OF CORRECTION: The could review any policies, ty processes for current ce for NG medication of the NG tube, and make sions. Appropriate staff could ding any changes. The DON of relop a system to monitor staff	r			
21015	MN Rule 4658.061 Requirements- Sa Subp. 7. Sanitary procedures and co	0 Subp. 7 Dietary Staff nitary conditi conditions. Sanitary nditions must be maintained in e dietary department at all	21015			
	by: Based on observat review, the facility f food service enviro to affect all 122 res	ent is not met as evidenced ion, interview and document ailed to maintain a sanitary nment. This had the potential idents in the facility.				
	Findings include:					
	A tour of the facility	dining room serving kitchens				

Minnesota Department of Health STATE FORM

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/19/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
21015	Continued From pa	age 26	21015			
	food service directed dietitian (RD)-A. The made and verified The 1 east serving heavy build-up of co surface. The inside contained consider	12/17/14, at 2:30 p.m. with the or (FSD) and Registered he following observations were by the FSD and RD-A: kitchen microwave oven had a debris on the interior top e of two of four drawers rable loose debris. The outside oboards were soiled with spills	a			
	soiled on the interior had a large spill of sticky. The FSD ve	y kitchen microwave oven was or surfaces. The refrigerator juice that had dried on and prified the oven and the t been kept up to standards.				
	on the outer surface had a build-up of c of the drawer locat wet. There were pa	kitchen cupboards were soled ces. Three of four cupboards rumbs and debris. The interior ed under the coffee maker was ackages of coffee in the drawe there was loose coffee grounds wer.				
	drawers with crum	g kitchen had two of six bs and debris. One of the disposable forks loose in the				
	manual can opene thick and sticky but face of the unit. Th up of metal shaving expect the can ope	202 p.m. with the FSD a r was observed with a heavy ild-up covering the blade and the cogs of the gears had a build g. The FSD said he would ener to be cleaned daily and n a sanitary condition.				
		nt cleaning schedule provided ted 12/14/14, lacked the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. DUILDING.			
		00872	B. WING		12/19/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
21015	Continued From pa	age 27	21015			
	policy dated 2011, the dining services sanitation techniqu prevent the outbreat SUGGESTED ME ⁻ food service directe any policies, proce safe food handling revisions. Appropri regarding any char or designee could staff for compliance	ng the can opener. A sanitation indicated it was the policy of department to practice proper es for clean equipment to ak of foodborne illness. THOD OF CORRECTION: The or or designee could review dures or facility processes for and make any necessary ate staff could be educated nges. The food service director develop a system to monitor e. R CORRECTION: Twenty-one				
21385		0 Subp. 3 Infection Control;	21385			
	Personnel must be infection control pr the residents and r	sistance with infection control. assigned to assist with the ogram, based on the needs of nursing home, to implement ocedures of the infection				
	by: Based on observat review, the facility of was performed and touching soiled iter	ent is not met as evidenced ion, interview and document did not ensure handwashing d gloves were changed after ns during the provision of dents (R89) reviewed for				
	Findings include:					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/19/2014	
					12/	19/2014
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
OLDEN	I LIVINGCENTER - H	OPKINS	IS, MN 55343	000111		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21385	Continued From pa	age 28	21385			
	R89 in the dining re- with assistance. -At 9:16 a.m. observed sightly of stationed R89's who observed slightly of the room briefly an- -At 9:19 a.m. observed slightly of the room briefly an- -At 9:19 a.m. observed slightly of the curtain the bed and set the car- room. -At 9:22 a.m. NA-Ar- room then left the re- bag with trash and room. -At 9:38 a.m. observed the Hoyer lift (mach shut the door upon was going to lay R8 -At 9:40 a.m. NA-Ar- going to find anoth down. -At 9:45 a.m. NA-Br- the lift sheet to the they both assisted bed.	rved NA-A going to room ent to R89's side of room hen moved R89 closer to the Il light on R89's lap and left the was observed going back to room briefly with a clear plastic went into the soiled utility rved NA-A going to room with hine used for transferring) and entering NA-A indicated he 89 down. left the room stated he was er staff to assist him to lay R8' a returned to room applied the	e e 9			
	undo R89's inconti incontinent then pr the front then as be	ed the lift sheet. :00 a.m. NA-A was observed nent pad stated R89 was not oceeded to provide pericare to oth NA's were turning R89 to d to urinate and was observed				
nonoto Di	to have stool comin	after completing the front				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00872	B. WING		12/19/2014	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		12/	15/2014
		725 SEC				
GOLDEN	N LIVINGCENTER - H	OPKINS	6, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21385	Continued From pa	age 29	21385			
	and donned two pa his hands then con the bottom wiped F movement never re- incontinent pad and bedding that was o lower extremities w her to the door and then went over to the bag with soiled line then removed the g this time still. -At 10:01 a.m. NA- room went to the se as he entered the r wash his hands be after finishing to do was supposed to w acknowledged he h after wiping resider bowel movement. -At 10:04 a.m. licer indicated NA-A was his gloves after per to wash his hands "That is an infection On 12/18/14, at 1:3 expectation on glow registered nurse (F of the facility infect "staff have been ta must take gloves o reapply new gloves Handwashing/Hand August 2012, direct their hands for at left	81 p.m. When asked what her ving, hand washing was N)-B who also was in charge ion control program stated ught when gloves are dirty they ff, wash their hands and				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00872	B. WING		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HO	OPKINS	S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21385	Continued From pa	age 30	21385			
		re and after assisting a ng (hand washing with soup				
	DON or designee of procedures or facili hand hygiene durin necessary revisions educated regarding	THOD OF CORRECTION: The could review any policies, ity processes for appropriate og cares and make any s. Appropriate staff could be g any changes. The DON or velop a system to monitor staff				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21565	MN Rule 4658.132 Medications Self Ad	5 Subp. 4 Administration of dmin	21565			
	self-administer med resident assessme care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document failed to ensure 2 of 2 resident safe to self-administer	S			
	Findings include:					
	a.m. The door was off. R128 was lying	observed on 12/17/14, at 7:22 wide open and the lights were on his back. erved nursing assistant (NA)-C				

STATEMEN	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00872			12/	12/19/2014	
IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST		12/	19/2014	
	I LIVINGCENTER - H	725 SE(COND AVENUE				
		НОРКИ	NS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21565	Continued From pa	age 31	21565				
	size amount of Ket a range of fungal s cream to the reside the drawer there w observed to be sto - At 7:57 a.m. the c drawer included Ke Ketoconazole crea treat fungal infectio inhaler (breathing r inhaler (breathing r inhalers were noted them which were n	e drawer and obtained pea oconazole cream (used to tre kin infections) and applied the ent's back. When NA-C opene as medications that were red in the drawer. observed medications in the etoconazole 1% shampoo, m 2%, Nystatin cream (used to ons) 100,000 units, Albuterol medication) and budesonide medication). In addition, both d to have a different name on ot R128's. R128 was not able time of observation.	e ed co				
	Assessment (CAAs R128 had Alzheime also hard of hearin	/dementia Care Area s) dated 9/17/14, identified er's and dementia. R128 was g which could impact his s. The CAA directed staff to e for his needs.					
	11/3/14, revealed the cream were ordered	er Summary Report dated he Ketoconazole shampoo an ed on 9/6/14. There was no d an order for the inhalers.	d				
	dated 12/16/14, inc administer medicat staff to store medic there would be a p	ation of R128's ability to					
	dated 12/16/14, inc self-administer me	f-Administration of Medicatior dicated R128 able to dications with setup by rsing was responsible for	IS				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00872	B. WING		12/19/2014		
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	OPKINS 725 SEC	OND AVENUE				
		HOPKIN	S, MN 55343			()(7)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21565	Continued From pa	age 32	21565				
	storage and for do	cumentation.					
	(DON) stated her e medications to be resident's room sta not be in his room. for the inhalers and self-administer the administering their	11 a.m. the director of nursing expectation regarding storing self-administered in a ated, "The medications should " R128 did not have an order d did not have an order to inhalers. R128 was not medications in a safe manner store the medications in a safe o self-administer.					
	p.m. and a bottle o tears for dry eyes) R124 claimed to ov stated had to "use recommended by " stated to have had bedside table and i by herself. -At 4:02 p.m. licens came to R124's roo presence of the ey table. -At 4:04 p.m. LPN- doctor's medication	observed on 12/15/14, at 4:00 f Refresh eye drops (artificial was on R124's bedside table. wn the bottle of eye drops and it three times a day" as 'eye doctor." R124 further the medication "all the time" a instilled the eye drops to eyes sed practical nurse (LPN)-F om and confirmed the e drops on R124's bedside F verified R124 did not have a n order for the Refresh eye ed he would "take care of it."					
	R124's care plan ir R124 as a resident receiving "care fror "safety is at risk." T remove R124 from situations. The car impaired vision rela	nitiated on 11/29/11, indicated t of the nursing facility was m someone else" and whose The care plan directed staff to potentially dangerous e plan also indicated R124 had ated to macular degeneration. section of the care plan was	1				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00872	B. WING		12/	12/19/2014	
AME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
OLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE 6, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21565	Continued From pa	age 33	21565				
	self-administer Ref	14, to add R124 can fresh eye drops and bottle of pt at R124's bedside.					
	dated 12/01 throug update was entere addition of the eye list. The MAR upda Solution [Carboxyn 2 drops in both eye	ministration Record (MAR) h 12/31/14, indicated an d on 12/15/14, reflecting the drops to R124's medication ate read, "Refresh Tears nethylcelluslose Sodium] Instill es three times a day for DRY E DR TO SELF ADMINISTER DSIDE."					
	were expected to c residents brought i residents and discu to obtain proper or assess residents for	52 a.m. the DON stated staff sheck medications that n to the facility, interview uss the medications; staff were ders for all medications; or safety in self-administration d ensure in safe keeping for					
	and General Guide Medications policy November 2011) d residents' high leve who desire to self-a permitted to do so team has determin safe for the resider facility and there is self-administer." Pr desires to self-adm assessment is con team of the resider orientation to time) carry out this respo	tion Administration-Preparation elines Self-Administration of dated 2006, (Revised irected "in order to maintain the el of independence, residents administer medications are if the facility's interdisciplinary ed that the practice would be nt and other residents of the a prescriber's order to rocedures A. If the resident ninister medications, an ducted by the interdisciplinary nt's cognitive (including , physical, and visual ability to onsibility during the care F. "Bedside medication					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/19/2014	
			A. BOILDING.			
		00872	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLE DATE
21565	Continued From pa	age 34	21565			
	a risk to confused i rooms of, or room v self-administer. Co BEDSIDE MEDICA bedside storage to SUGGESTED MET DON or designee of procedures or facili administration of m necessary revisions educated regarding designee could dev for compliance.	nditions outlined in 4.3: TION STORAGE are met for				
21590	Administering Drug All medications, inc nursing home by a administered only i order signed by a h licensed to prescrib order may be given the order is done a This MN Requirem by: Based on observat failed to ensure 2 of	cluding those brought into a	21590			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/19/2	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GOLDEI	N LIVINGCENTER - H	OPKING	OND AVENUE S, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21590	R128's room was of a.m. The door was off. R128 was lying - At 7:54 a.m. obse pull bedside drawe amount of Ketocom range of fungal skin cream to the reside the drawer there we observed to be stor - At 7:57 a.m. the of drawer included Ke Ketoconazole crea- treat fungal infection inhaler (breathing r inhaler (breathing r noted to have a diff was not R128's. R1 the time of the obse The Cognitive loss Assessment (CAAs R128 had Alzheime also hard of hearin cognition and cares continue to provide The physician Orde 11/3/14, revealed th cream were ordere evidence R128 had R128's Self-Medica dated 12/16/14, ind administer medicat staff to store medic there would be a po	bbserved on 12/17/14, at 7:22 wide open and the lights were on his back. erved nursing assistant (NA)-C r open and obtained pea size azole cream (used to treat a n infections) and applied the ent's back. When NA-C opened ere medications that were red in the drawer. bbserved medications in the etoconazole 1% shampoo, m 2%, Nystatin cream (used to ons) 100,000 units, Albuterol medication) and budesonide medication). Both inhalers were ferent name on them which 128 was unable to converse at ervation. //dementia Care Area s) dated 9/17/14, identified er's and dementia. R128 was g which could impact his s. The CAA directed staff to for his needs. er Summary Report dated he Ketoconazole shampoo and d on 9/6/14. There was no d an order for the inhalers. ation Administration care plan dicated the R128 would safely itons. The care plan directed eations in a secure location and eriodic safety ation of R128's ability to				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00872	B. WING	B. WING		12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE	
				DEFICIENC	CY)		
21590		-	21590				
	dated 12/16/14, inc self-administer me	f-Administration of Medications dicated R128 able to dications with setup by rsing was responsible for cumentation.	3				
	R128 could self-ad	20 a.m. LPN-A was asked if minister medications. RN-A administer medications					
	(DON)stated her ex medications to be s	1 a.m. the director of nursing xpectation regarding storing self-administered in a ated, "The medications should					
	p.m. and a bottle o tears for dry eyes) R124 claimed to ov stated had to "use recommended by " stated to have had bedside table and i by herself. -At 4:02 p.m. licens came to R124's roo presence of the eye table. -At 4:04 p.m. LPN- doctor's medication	bbserved on 12/15/14, at 4:00 f Refresh eye drops (artificial was on R124's bedside table. wn the bottle of eye drops and it three times a day" as 'eye doctor." R124 further the medication "all the time" at instilled the eye drops to eyes sed practical nurse (LPN)-F om and confirmed the e drops on R124's bedside F verified R124 did not have a n order for the Refresh eye ed he would "take care of it."	t				
	R124's care plan ir R124 as a resident receiving "care fror "safety is at risk." T remove R124 from	a he would "take care of it." hitiated on 11/29/11, indicated t of the nursing facility was m someone else" and whose The care plan directed staff to potentially dangerous e plan also indicated R124 had					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
OLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21590	Continued From pa	age 37	21590				
	The interventions s updated on 12/15/ self-administer Ref eye drops to be ke The Medication Ad dated 12/01 throug update was entere addition of the eye list. The MAR upda Solution [Carboxyn 2 drops in both eye	ated to macular degeneration. section of the care plan was 14, to add R124 can iresh eye drops and bottle of pt at R124's bedside. ministration Record (MAR) th 12/31/14, indicated an d on 12/15/14, reflecting the drops to R124's medication ate read, "Refresh Tears nethylcelluslose Sodium] Instill es three times a day for DRY E DR TO SELF ADMINISTER DSIDE."					
	were expected to c residents brought i residents and discu to obtain proper or assess residents for	52 a.m. the DON stated staff sheck medications that n to the facility, interview uss the medications; staff were ders for all medications; or safety in self-administration d ensure in safe keeping for					
	and General Guide Medications policy November 2011) d residents' high leve who desire to self-a permitted to do so team has determin safe for the resider facility and there is self-administer." Pr desires to self-adm assessment is con team of the resider	tion Administration-Preparation elines Self-Administration of dated 2006, (Revised irected "in order to maintain the el of independence, residents administer medications are if the facility's interdisciplinary ed that the practice would be nt and other residents of the a prescriber's order to rocedures A. If the resident ninister medications, an ducted by the interdisciplinary nt's cognitive (including , physical, and visual ability to					

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00872	B. WING		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO)PKINS	OND AVENUE 6, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21590	planning process." storage is permitted a risk to confused r rooms of, or room v self-administer. Con BEDSIDE MEDICA bedside storage to SUGGESTED MET DON or designee c procedures or facili standards of practic home, and make an Appropriate staff co any changes. The I develop a system to	nsibility during the care F. "Bedside medication d only when it does not present esidents who wander into the vith, residents who nditions outlined in 4.3: TION STORAGE are met for	21590			
21610	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe only authorized nur access to the keys. This MN Requireme by: Based on observati did not ensure expi discarded; medicat	of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have	21610			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00872	B. WING		12/	19/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		725 SEC	OND AVENUE	SOUTH		
GOLDEN	I LIVINGCENTER - H	HOPKINS HOPKINS	6, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	age 39	21610			
	2 East Unit/ North- On 12/18/14, at 11: the 2 East medicat ready to use medic A half-full bottle of t (medication for hyp on 9/10/14; an ope and an opened bot which had no labels opened.	side Medication Cart 18 a.m. during inspection of ion cart, where the following ation were observed: facility supply Tums peracidity) which was expired ned bottle of Levemir insulin tle of Novolog insulin for R81 s as to when they were				
	powder build up at contained 17 packa 3rd and 5th drawer observed to have the the back and sides	as with thick, pink and white the back. The drawer ages of pills. In addition, the s of the medication cart were nick, white powder build-up on with multiple pieces of foil and ubble packages of pills.				
	nurse (LPN)-E veri medications and m indicate when they stated nurses were carts at the end of	36 a.m. licensed practical fied the presence of expired edications with no dates to were opened. LPN-E also supposed to clean medication every shift and night nurses ake sure medication carts				
	On 12/19/14, at 9:3 check the medicati the following ready observed: a bottle of (pain reliever and a 220 milligrams (mg bottle of mineral oil had no expiration of (pain reliever crean	side Medication Cart 9 a.m. LPN-G agreed to on cart with surveyor, where to use medication were of facility supply Naproxen unti-inflammatory medication)) which was expired on 8/14; A with no name written and also late; R101's Trixaicin cream n) and a Silverstat antibacterial itment had no expiration dates;				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
			_				
		00872		B. WING		19/2014	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST OND AVENUE				
OLDEN	I LIVINGCENTER - H	OPKINS	S, MN 55343	500111			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21610	Continued From pa	age 40	21610				
	eye and reduces eye discomfort) 1% solution which was expired on 11/14.						
	also observed to be substances. A mee the 4th drawer of th with thick, cream-c The 4th drawer als back and there we drawer floor. LPN-c responsible in clea medications were o	of the medication cart was e dirty with white powdery dication/treatment bin placed in ne medication cart was dirty olored and greasy substance. o had white powders at the re four white loose pills on the G stated nurses were ning carts and making sure current. LPN-G agreed the awers were dirty and stated sho					
	Medication Room v following ready to u an open bottle of h international units (R141's unopened k (anti-anxiety medic expired on 8/14; LF back to narcotic bo back in the refriger put the expired me	ation Room 10:04 a.m. the 2 West was checked with LPN-H. The use medication were observed ouse stock of Vitamin D-400 (IU) with no expiration date; bottle of liquid Ativan eation) 2mg/ml which was PN-H placed the liquid Ativan bx, locked the box and put it ator. LPN-H stated she had to dication back in the locked box es were needed to discard it.					
	(DON) stated nurse carts. The DON ad	21 a.m. the director of nursing es were expected to clean the ded the facility's policy was no d undated medications in the nd rooms.					
	The director of nursi development and in	THOD OF CORRECTION: sing (DON) or designee could mplement policies and itor expiration of medications					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING		12/	19/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVINGCENTER - HO	OPKINS	COND AVENUE IS, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21610	Continued From pa	ge 41	21610				
	director of nursing	the medication cart. The or her designee could then riate staff for adherence to the lures.)				
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)					
21630	MN Rule 4658.135 Medications; Destru	0 Subp. 2 A.B. Disposition of uction	21630				
	remaining in the nu discharge of a resid prescribed, or any of discontinued perma manner recommen or the consultant pl pharmacist must fu instructions and for kept on file in the n B. Unused port drugs remaining in death or discharge were prescribed or discontinued perma according to part 6 be returned to the p 6800.2700, subpart destruction listing th medication, prescri person destroying to	tions of controlled substances rsing home after death or dent for whom they were controlled substance anently must be destroyed in a ded by the Board of Pharmac narmacist. The board or the rnish the necessary ms, a copy of which must be ursing home for two years. tions of other prescription the nursing home after the of the resident for whom they					
	This MN Requirem	ent is not met as evidenced					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - HO	OPKINS	OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21630	Continued From pa	age 42	21630				
	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:						
	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.		K S S				
	R56 had an order f 75 microgram (mcg R56's diagnoses in	Orders dated 11/5/14, indicated for the Fentanyl patch 72 hour g)/hour (patch used for pain). Included mylagia and myositis, and aftercare for bealing	k				
nnonoto D	hip joint replaceme	icluded mylagia and myositis, ant and aftercare for healing of hip obtained from Admissior	1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00872	B. WING		12/	19/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
(X4) ID		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21630	Continued From pa	age 43	21630			
	Record dated 12/1	2/2014.				
	Administration Rec through 12/18/14, i Fentanyl patch rem times with only one be determined if th one nurse signed of and applying of the On 11/6/14, at 1:42 facility policy for bo	56's Electronic Medication cord (EMAR) dated 12/1/14 it was revealed R56 had the noved and disposed of six e nurse signing off. It could not here were two nurses as only off for the removal, destruction e Fentanyl patch. 2 p.m. DON stated it was the oth nurses to document narcotic book upon completing				
	05/12, directed "W medication is remo administration but given for any reaso container. It is dest licensed nurses , a on the accountabili representing that d indicate who was r narcotic books wer nurses were consis	nce Disposal policy dated hen a dose of a controlled oved from the container for refused by the resident or not on, it is not placed back in the troyed in the presence of two and the disposal is documented ity record/book on the line lose" The policy did not esponsible to oversee the re audited regularly to ensure stently documenting Fentanyl prevent potential diversion.	ł			
21665	MN Rule 4658.140	0 Physical Environment	21665			
	functional, comfort environment, allow	ust provide a safe, clean, able, and homelike physical ring the resident to use gs to the extent possible.				
	This MN Requirem	ent is not met as evidenced				

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STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED		
		00872			12/	12/19/2014		
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE				
OLDEN	I LIVINGCENTER - H	OPKINS	COND AVENUE NS, MN 55343	SOUTH				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
21665	Continued From pa	age 44	21665					
	review, the facility f (R102) room was k reviewed for enviro	ion, interview and document failed to ensure 1 of 4 residen kept clean and free of odors inmental concerns.	its					
	Findings include:							
	depression, seizure obtained from the o (MDS) dated 10/9/ indicated R102 had memory problems, one staff with toilet	dementia, hemiplegia, e disorder and chronic pain quarterly Minimum Data Set 14. In addition, the MDS d both short and long term required total dependence of use and all other activities of I an indwelling catheter.						
	walking down the h tour a strong musty outside R102's roo observed R102 lyir off from the hallway (RN)-A entered the -At 4:52 p.m. the m was not able to sm for a while and wou be able to pick the -At 4:56 p.m. house approached survey	ekeeping account manager or indicated she wanted to go ut at the time R102's wife wa	e or Id					
	manager indicated she was not sure w going into the bath room.	43 p.m. housekeeping accour the smell was urine smell an where it was coming from afte room and started to clean the rved housekeeping account	d r					
		lees spraying the floor as she						

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE				
		725 SE	COND AVENUE				
GOLDEN	I LIVINGCENTER - H	HOPKINS HOPKI	NS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From pa	age 45	21665				
	strong musty smell administering R102 it was urine smell a suprapubic cathete	a asked if he had noticed the in the room when 2's medications RN-A indicate and further stated R102 had a er and was at times incontiner why there was a urine smell i	t l				
	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.		o en				
	remained to have a staff, residents and observed going pa- located down the h	10 a.m. to 3:00 p.m. room a strong urine smell. Several I family members were st the room to other rooms allway back and forth. No sta 02's room needed to be	ıff				
	room noted still to was noticeable from room in the hallway at the time and sev including the direct director and the ex -At 9:22 a.m. surve nurse (LPN)-A wern and where the sme stated R102 had a was where the sme	80 a.m. to 9:22 a.m. R102's have a strong urine smell that in standing or walking past the y. R102's door was wide oper veral staff going by the room or of nursing, maintenance ecutive administrator. eyor and licensed practical at to room when asked what ell was coming from LPN-A catheter bag and thought that ell was coming from and change the catheter bag to	e ו				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00872	B. WING		12/19/2014	
AME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
GOLDE	N LIVINGCENTER - H		COND AVENUE NS, MN 55343	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	-At 9:30 a.m. both housekeeping accorroom both acknowly when maintenance the room he stated smell from standing hallway. Maintenarr us figure this out whe turned to the ho and asked what tim to coordinate with more room to be deep cl On 12/18/14, at 8:1 (DON) stated she a identified the urine sure of the time an R102's room to be expected staff to ha housekeeping as s stated "Of course." On 12/19/14, the h requested but was content was provid SUGGESTED MET DON or designee of procedures or facil malordous room for necessary revision educated regarding designee could dev for compliance.	maintenance director and bunt manager approached the ledged the smell was urine ar e director was asked to enter the was able to smell the urin g outside the room in the finde director further stated "Le re are thinking it's the mattres busekeeping account manage the she wanted housekeeping hursing to get R102 up for the eaned. 16 a.m. the director of nursing and the executive director had smell on 12/17/14, but was n d had started to coordinate for cleaned. When asked if she ave reported the smell to soon as it was notice DON	nd le t s" r ot ot ot ot ff			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		725 SEC	OND AVENUE				
GOLDEN	I LIVINGCENTER - HO	HOPKINS HOPKIN	S, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ige 47	21805				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805				
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by: Based on observative review, the facility of treatments were im (R165, R85) observion one resident (R73) administration throut In addition, the facility a choice of condimentation	ent is not met as evidenced ion, interview and document did not ensure dignified plemented for two residents ved in the dining room and to observed for medication ugh gastrostomy tube (g-tube) lity failed to offer the residents ents at meals. This had the II 35 residents on the 2 west					
	Findings include:						
	the 1 East dining ro with two other resid Nursing assistant (I on R165's left side was no verbal cueir communication obs R165, aside from th full of food to R165 from R165's table e regular tone of com another resident at	5 a.m., R165 was observed at bom, seated in wheelchair and lents at the dining table. NA)-D was seated in a chair and was feeding R165. There ing heard or any other form of served between NA-D and he acts of NA-D giving spoons . Surveyor was within range enough to have heard any versation such as that from the same table, R125, who anting to go back to room but					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00872	B. WING		12/19/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
		725 SEC	OND AVENUE			
GOLDEI	N LIVINGCENTER - H	HOPKINS	S, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 48	21805			
	observed for at lea food from mouth de was observed to or spoon full of food b time that food were mouth, NA-D used wipe the corners of -At 8:55 a.m. NA-D feed R165. NA-D w thickened liquid con he remained stand two plastic cups on to be empty, while about 75% of unfin -At 8:58 a.m. NA-D clothing protector, f R165's neck, put it R165's wheelchair. before or while doin -At 9:00 a.m. NA-D wheelchair out from hallway and to R16 in wheelchair inside bed; the room door positioned R165's f locked the wheelch button on R165's fa without talking to R -At 9:04 a.m. R165 surveyor knocked a R165 was able to r greeted. R165 nod asked to verify that the time NA-D was room to R165's bee room. However, wh question to ask if N he was doing, R165	R165. In addition, R165 was st three times having spilled own to clothing protector, as hly take small bites from the being fed by NA-D. For each e being spilled from R165's R165's clothing protector to f R165's mouth and chin. 0 stood up and continued to vas feeding R165 with ntained in a plastic cup while ing on R165's left side. The n R165's table were observed there were two bowls with ished food in each. 0 wiped R165's mouth with the took the clothing protector off on the table, and then moved . NA-D never spoke to R165 in the dining room to the 55's room. NA-D pushed R165's in the dining room to the 55's room. NA-D pushed R165 e the room towards R165's r was left open. NA-D wheelchair to face door, then hair brakes. NA-D placed call ap then left the room, still R165. 6 looked towards the door wher and signified to enter room. naintain eye contact when ded to agree when surveyor t NA-D never talked all through with R165 from the dining droom and until NA-D left the nen surveyor re-phrased JA-D talked or explained what 5 just stared at surveyor then k at the television show on				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
AME OF I	PROVIDER OR SUPPLIER		EET ADDRESS, CITY, S	DDRESS, CITY, STATE, ZIP CODE			
OLDEN	I LIVINGCENTER - H	OPKINS	SECOND AVENUE PKINS, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	age 49	21805				
		Vhen asked if R165 felt D's treatment, R165 kept o he television.	quiet				
	indicated R165's sa medical conditions include altered mer communicate in Er staff to do the follow procedures and ca provide reality orien short phrases and no answers and us verbal reminders w orientation; explain environment; use of pictures as needed	e plan, initiated on 12/23/1 afety was at risk in relation and clinical manifestation ntal status and limited abil nglish. The care plan direc wing interventions: explain res before performing the ntation while giving care; u questions which require ye be gestures as needed; use which assist patient in what was going on in the communication book or I to help with communicati terpreter as needed.	n to s to ity to ted n all m; ise es or e				
	9/24/14, indicated l communication, an ability, as would on and communicate s to "use simple mea include gestures an CAA also indicated psychosocial well-b	essments (CAA) dated R165 had problem with ad had limited English spea ly able to understand som some. The CAA indicated ans of communication" to and communication book. T I R165 had problem with being related to change in ad with the diagnoses of ression.	e staff				
	electronic Admissio	rmation section of R165's on Record indicated R165 ve care on 12/3/14.	was				
	change in status da did not speak word	Pata Set (MDS) for significated 12/10/14, indicated R ls, and rarely had the abilit	165 y to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00872	B. WING		12/	12/19/2014	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - HO		OND AVENUE S, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21805	Continued From pa	ige 50	21805				
	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.						
	understood English added R165 would something. NA-D d observations that h explanations regard he was with R165 i until he took R165 NA-D did not deny	21 p.m. NA-D stated R165 a but "would take time." NA-D nod if was in agreement with id not deny surveyor's e did not give any ding his actions during the time n the dining room for breakfas back to room and until he left. that he was standing beside inued to feed R165 with	t				
	open. R85 was obs beside bed, with ey quiet. -At 7:44 a.m., a NA knocking on door, a saying a word, star brakes. NA-A called R85's hand but R85 NA-A pushed R85's hallway then to the at a table, locked w without talking to R -At 7:52 a.m. R85 r on the same spot w	emained seated in wheelchair /here NA-A had parked the	r 5				
	was alone at table. residents in the din present.	eyes remained closed. R85 There were four other ing room but no staff was ary staff was observed					

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	ta Department of He					
AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00872	B. WING		12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	OPKINS	COND AVENUE	SOUTH		
		ΗΟΡΚΙΝ	IS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ige 51	21805			
	working in the mini- closed. R85 was we protector. -At 8:19 a.m. R85 h wheelchair's head n was served at R85' -At 8:31 a.m. R85 w spot in the dining ro- closed. -At 8:37 a.m. R85 s dining table. A glas juice were observe- -At 8:42 a.m. a NA- breakfast plate to F providing R85 with and was talking to h R85's electronic Ad- indicated R85 had Alzheimer's disease The care plan initia had cognitive loss a making capabilities issues. The care pl environmental cues The care plan also remain comfortable care plan further di themselves when a living and staff were	-kitchen. R85's eyes were still earing a green clothing nad leaned head towards rest, with eyes closed. No food	e I,			
	for the process of r through g-tube to F -R73 was lying in b	26 a.m., LPN-E was observed nedication administration 173. ed with the head of bed 15 degrees. An ongoing tube				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00872				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	B. WING		12/19/2014		
AME OF I	PROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•		
	I LIVINGCENTER - H		25 SECOND AVENUE	SOUTH			
		H 100 H	IOPKINS, MN 55343			1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL SC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21805	Continued From pa	age 52	21805				
	contained approxim feeding formula att LPN-E did not corre- the right position for explain what he wa -Without saying a w nurse (LPN)-E turn disconnected it from -LPN-E administer R73's g-tube withon paused to check he during the whole m procedure. R73's e doing. -After the medication R73's g-tube, LPN- tube and turned it of R73 that he was do	ved, with a bottle that nately 50 milliliters (ml) ached to R73 through g ect nor made sure R73 or tube feeding. LPN-E of as going to do to R73. word to R73, Licensed p red off the tube feeding m the g-tube connection ed the medications throut talking to R73. LPN-I ow R73 felt. R73 was q redication administratio eyes followed what LPN ons were administered the re-connected the feed on. LPN-E did not verbat one giving medication. It t on top of R73's abdom f the room.	g-tube. was in did not practical then n site. bugh E never uiet n -E was via eding alize to _PN-E				
	indicated R73's sat potential for abuse cognition, inability t care and decrease plan directed staff them; and to explai	plan initiated on 4/3/13 fety was at risk and hac related to decreased to communicate, need f d physical ability. The o to explain actions befor in environment to help l nat was going on aroun	l for total care e doing keep				
	(DON) stated it was	52 a.m. the director of n s her expectation for sta dignity at all times.					
	Procedures Manua Subject: SS-702 D	I Services Policies and al, Section 7: Residents ignity dated as revised residents will be treate	on d with				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		00872	B. WING		12/	12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - H	NDKINS	COND AVENUE IS, MN 55343	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	resident's self-wort psychosocial well-k policy directed staf friendly and patient resident as an indiv	h and improve his/her being and quality of life. The f to speak to residents in a a manner, and to focus on the vidual when talking to them. In directed staff to respect	21805				
	were no evidence of the tables, and the or pepper packets also no sugar pack - At 8:35 a.m. nurs were interviewed a residents wanted s observation there w the dining room as salt and/or pepper. packets on the tabl eating their eggs w - At 8:45 a.m. Cool of nursing explaine packets in the cupt need to ask for it. T and pepper shaker residents would so their food or unscre- them out anymore.	30 a.m. at breakfast, there of salt or pepper shakers on re was no evidence of any salt having been used. There were tets available on the tables. ing assistants (NA)-G, NA-H nd stated they were to ask if alt or pepper. During the meal was no observation of staff in king residents if they wanted The tables were void of empt les. Residents were observed ithout salt or pepper. <-A and the assistant director id, there were salt and pepper poard and the residents would They went on to explain salt is were used in the past, but metimes pour too much on ew the top, so they do not put They verified that not all to request condiments.	э У				
	dining room were of plastic bags of salt for the staff to offer	t5 a.m. the cupboards in the observed and there large and pepper packets available the residents. The residents he choice of sugar, salt and/o					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00872	B. WING		12/	19/2014
ME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
OLDEN	LIVINGCENTER - H	OPKINS	OND AVENUE S, MN 55343	SOUTH		
X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	ION SHOULD BE	(X5) COMPLET DATE
ind		,	ind	DEFICIENC		
21805	Continued From pa	age 54	21805			
	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 FO (21) days.	R CORRECTION: Twenty-one				