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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 43AH
Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2. STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/24/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **72** (L18)

13. Total Certified Beds **72** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 10/31/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/30/2013
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5394

At the time of the standard survey completed August 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On September 23, 2013, the Minnesota Department of Health and, on October 24, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 1, 2013, effective September 30, 2013. Therefore, the remedies outlined in our letter dated August 20, 2013, will not be imposed.
See attached CMS-2567B forms for the results of the September 23, 2013 and October 24, 2013 revisits.

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5394 December 24, 2013

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

Dear Mr. Carlson:

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 September 30, 2013 the above facility is certified for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

October 31, 2013

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5394024

Dear Mr. Carlson:

On August 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 1, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 23, 2013, the Minnesota Department of Health and on October 24, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2013, effective September 30, 2013 and therefore remedies outlined in our letter to you dated August 20, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Enclosucc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245394	A. Building B. Wing	9/23/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**09/10/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/10/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**09/10/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**09/10/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**09/10/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**09/10/2013**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	**09/10/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	SR/cbl	10/31/2013	16022	09/23/2013
Reviewed By CMS RO				

Followup to Survey Completed on: 8/1/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245394	01 - MAIN BUILDING 01	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	09/30/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	10/31/2013	12424	10/24/2013
CMS RO				

Followup to Survey Completed on: 7/30/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 43AH
Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245394**
2. STATE VENDOR OR MEDICAID NO. (L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **72** (L18)

13. Total Certified Beds **72** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Beth Lacina, HFE NEII — 09/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 09/30/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/30/2013** (L33)

DETERMINATION APPROVAL

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

CCN# 24-5394

At the time of the standard survey completed August 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4059

August 20, 2013

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5394024

Dear Mr. Carlson:

On August 1, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<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:

Susanne Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

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 September 10, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 1, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106   Fax: (651) 215-9697

Enclosure

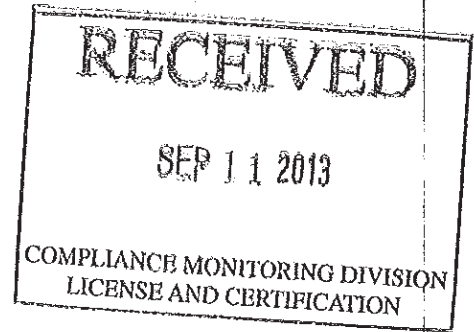
cc: Licensing and Certification File   5394s13.rtf

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

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On July 29, 2013 through August 1, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280 POC accepted ~~9/3/13~~ 9/13/13 SER		

RECEIVED
SEP 11 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] LNHA | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 9/6/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING ________ B. WING ________	08/01/2013

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F 280	Continued From page 1 Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 1 resident (R10) in the sample who required assistance with ambulation. Findings include: During an observation on 7/31/13, R10 ambulated 40 feet with physical therapy in the hallway using the front wheeled walker (FWW) and stand by assistance. When interviewed on 8/1/13, at 8:20 a.m. the physical therapist indicated R10 had been on a maintenance program since 8/23/11 according to the Maintenance Program document which contained six caregiver signatures acknowledging the instructions to walk R10 75 feet two times per day. Interviews with the day nursing assistants were conducted on 8/1/13, between 9:00 am and 9:30 am. Nursing assistants (NA)-A, NA-B, NA-C, and licensed practical nurse (LPN)-A all indicated working full time and being long term employees,and all referenced R10 walked in therapy but not on the unit in the hallway by the nursing staff. Registered nurse (RN)-A was new to the facility and was unable to find any restorative ambulation documents for R10 indicating ambulation by nursing staff in the hallway. R10 was assessed to require assistance to ambulate and the physician order read to ambulate 75 feet twice a day however this information was not added to the plan of care, and staff did not ambulate R10 in the hallway. The physician order directed "to walk 75 feet twice per day with FWW and assisting of 1.	F 280	F 280 • R10 is being assisted to ambulate per physicians orders. R10 Care Plan was reviewed and updated to include current ambulation program. • Residents on physician ordered maintenance programs will be reviewed to ensure they are receiving maintenance program if indicated. Care plans will be reviewed and revised as needed to include current maintenance programs. • Nursing staff have been educated on the requirements to complete restorative programs as ordered and maintaining documentation of program completion. Licensed staff will be educated on updating ambulation status care plans. • DNS/Designee will complete weekly random audits to ensure compliance and will report progress of audits to the QA committee. • The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations. • DNS is responsible • Completion date: September 10, 2013.	

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F 280	Continued From page 2 Follow with W/C [wheel chair}." The physical therapy maintenance program form directed caregivers to walk R10, 75 feet two times per day.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R10) reviewed for repositioning and 2 of 3 residents (R3, R10) reviewed for urinary incontinence. Findings include: R10 was assessed to require assist with repositioning, and assist with toileting and did not receive assistance in accordance with the plan of care interventions. R10's care plan dated 6/26/13, diagnosis included dementia, directed staff to assist R10 to turn, reposition, offload and check for incontinence every two hours. During continuous observation on 8/1/13, R10 was seated in the dining room from 6:45 am until 9:30 am when R10 was taken to the bedroom and was stood with the assistance of one staff	F 282	F 282 • R10 is being repositioned and incontinence care is being provided per Plan of Care; R3 is having incontinence care provided per Plan of Care. • Other residents requiring assistance with repositioning or incontinence care are being assisted as indicated in their Plan of Care. • Nursing staff has been educated regarding the importance of following the Care Plan. • DNS/Designee will conduct random weekly audits to ensure staff are following the toileting and repositioning Care Plans. • The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations. • DNS is responsible • Completion date: September 10, 2013	

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F 282 Continued From page 3 F 282

member for offload and incontinence care.

Interview on 8/1/13 with nursing assistant (NA-B) verified R10 required every two hour repositioning and incontinence care. R10 had creases and crevices to skin in buttock area from the incontinent brief and R10 had been incontinent of urine.

The facility failed to ensure the incontinence plan of care was followed for R3. R3 was not checked for incontinence or offered to be changed for three hours.

The Care Plan, last revised 7/13/13, directed staff "Resident is incontinent of bowel and bladder. Wears incontinent product to maintain dignity, protect clothing. Staff changes resident after incontinent episodes, completes pericare with all changes. Resident is checked q 2h and prn. [every 2 hours and as needed] Resident will also indicate a need to be changed by pointing at or grabbing crotch." Goals included, "Resident will have no skin breakdown r/t [related to] incontinence x 90 days." Interventions included, "Use of briefs/pads for incontinence protection."

On 7/31/13, R3 was observed finishing breakfast in the dining room at 8:12 a.m., then wheeling himself away from the table. At 8:35 a.m. R3 was observed in his room, taking a disposable brief out of an overhead cabinet and placing it on his reclining chair. R3 remained in is room. At 9:27 a.m. the resident assessment nurse, (RN)-Y walked in and asked if R3 wanted to lay down. R3 declined. The door remained open and the interaction lasted less than a minute. At 9:30 a.m. R3 rolled himself to the dining room, where he was observed to drink a sports beverage. At 9:50

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F 282	Continued From page 4 a.m. a floor nurse, (FN)-A, asked if R3 wanted to lay down as he was leaning over the table. At 10:20 a.m. the social worker (LSW)-C sat next to R3, greeted him and did some paperwork. No offer to change briefs was made. At 10:22 a.m. R3 wheeled himself to the nurse cart and got a cookie. At 10:27 a.m. R3 was in his room, calling out "hey" in a high pitch voice. At 10:50 a.m. an activity assistant (AA)-B, entered the room and invited R3 to a group. No offer to toilet was made. AA-B wheeled R3 to a ball toss group. At 11:29 a.m. R3's nursing assistant, (NA)-Z, entered the room with a mechanical lift. R3 declined to allow surveyor to observe. At 11: 35 a.m. NA-Z reported he offered toileting to R3 "after breakfast" but R3 refused. R3 reported he did not offer R3 an opportunity to toilet again until he entered the room again at 11:29 a.m. NA-Z reported R3 was "a little" wet. NA-Z reported he told a nurse about R3's refusal. Immediately following interview with NA-Z, both floor nurses, FN-A and FN-B, reported they were not aware of R3 refusing any cares that morning. FN-B reported R3 would normally grab his crotch and make a high pitch "hey, hey hey" noise when he has to be changed. FN-B reported R3 should be checked for incontinence and changed as needed every two hours. On 8/1/13 at 8:41 a.m. the director of nursing [DON] reported that there were no written policies related to following the care plan. DON explained staff should be following the plan of care as directed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		

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F 311	Continued From page 5 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 3 residents (R10) in the sample who were reviewed for ambulation. Findings include: R10's record was reviewed and indicated R10 had been assessed to require assistance to ambulate and the physician order read to ambulate 75 feet twice a day, however, this information was not added to the plan of care and staff was not ambulating10 in the hallway. During an observation on 7/31/13, at 10:00 a.m,. R10 ambulated forty feet with physical therapy in the hallway using a front wheeled walker (FWW) and stand by assistance. When interviewed on 8/1/13, at 8:20 a.m. the physical therapist stated R10 had been on a maintenance program since 8/23/11and nursing staff were to be sure R10 walked 75 feet two times per day. The Maintenance Program document, which contained six caregiver signatures acknowledging the instructions, directed staff to walk R10 75 feet two times per day. The therapist indicated the expectation was for nursing to ambulate R10 according to the maintenance program and physician orders.	F 311	F 311 • R10 is being assisted to ambulate per Physicians Order. R10 Care Plan was reviewed and updated to include current ambulation program. • Care Plans, doctor orders and Functional maintenance plans for residents who require assist with ambulation have been reviewed and revised as needed. • Nursing staff have been educated on the requirements to complete restorative programs as ordered and maintaining documentation of program completion. • DNS/Designee will complete weekly random audits of ambulation care plans and documentation to ensure compliance and will report progress of audits to the QAPI committee. • The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations. • DNS is responsible • Completion date: September 10, 2013	

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F 311	Continued From page 6 The physician order directed: "walk 75 feet twice per day with front wheeled walker (FWW) and assisting of 1. Follow with W/C {wheel chair}." The physical therapy maintenance program directed caregivers to walk R10, 75 feet two times per day. The nursing assistant ADL Flow Sheet Log addressing walk in hall was marked to indicate the activity did not occur. Interviews with the day care givers were conducted on 8/1/13, between 9:00 am and 9:30 am. Nursing assistants (NA)-A, NA-B, NA-C, and licensed practical nurse (LPN)-A all indicated working full time and being long term employees. All referenced R10 walks in therapy but not on the unit by the nursing staff. Registered nurse (RN)-A was new to the facility and was unable to find any restorative ambulation documents for R10 indicating ambulation by nursing staff in the past quarter.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident	F 314		

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F 314	Continued From page 7 (R10) at risk for skin breakdown was repositioned as assessed, to minimize or prevent skin breakdown from occurring. Findings include: During continuous observation on 8/1/13, R10 was seated in the dining room from 6:45 am until 9:30 am when R10 was taken to the bedroom and was stood with the assistance of one staff member to offload and be repositioned. Nursing assistant (NA)-B acknowledged R10 required every two hour repositioning. Observations revealed that R10 had creases and crevices to skin in buttock area from the incontinent brief and R10 was incontinent of urine. R10's care plan dated 6/26/13, diagnosis included dementia and directed staff to assist R10 to turn, reposition, and offload and check for incontinence every two hours. When interviewed on 8/1/13, at 9:45 a.m. NA-B confirmed R10 was to be re-positioned every two hours and today acknowledged R10 had gone 2 hours and forty-five minutes. NA-B further revealed being assigned to another unit but had come to assist with residents who required assist after breakfast care in R10's unit.	F 314	F 314 • R10 is being repositioned per Plan of Care. • Other residents requiring assistance with repositioning care are being assisted as indicated in their Plan of Care. • Nursing staff has been educated regarding the importance of following the Care Plan. • DNS/Designee will conduct random weekly audits to ensure staff are following the care plan in regards to repositioning. • The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations. • DNS is responsible • Completion date: September 10, 2013	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	Continued From page 8	F 315		

who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide 2 of 3 residents (R3, R10), with the services for toileting needs.

Findings include:

During a standardized initial interview on 07/30/13 at 9:13 a.m., a family member of R3, (F)-X, reported she had seen R3 sitting in wet briefs on several occassions. F-X reported R3 would not accurately report if he needed to be changed, due to not wanting to bother staff. F-X reported she visisted on a regular basis and was familiar with R3's lifestyle and routine prior to entering the facility.

A review of R3's care area assessment (CAA), dated 7/19/12, indicated R3 was always incontinent of urine and required extensive assistance with toileting, The CAA read "Resident is incontinent of bowel and bladder. Wears incontinent product to maintain dignity, protect skin and clothing. Resident checked q2h [every 2 hours] and prn [as needed]. Able to notify staff after incontinent episodes. Dependent on staff for changes. Pericare completed with all changes." A section entitled Resident and/or Family Representative directed staff "Provide input from resident and/or family representative regarding this care area.

F 315

- R3 and R10 are being toileted per plan of care. Care Plans are being reviewed and revised as needed.
- Other residents requiring assistance with incontinence care are being assisted as indicated per assessment and care plan.
- Education to nursing staff regarding the importance of following the Care Plan.
- DNS/Designee will conduct random weekly audits to ensure staff are following the toileting Care Plans.
- The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations.
- DNS is responsible
- Completion date: September 10, 2013

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F 315	Continued From page 9 (Questions/Comments/Concerns/Preferenes/Suggestions)" The section was left blank. Informatin regarding family input was not provided in the Urinary Incontinence and Indwelling Catheter CAA. The Cognitive Loss/Delirium CAA, dated 7/19/2013, indicated R3 had short and long term memory problems, moderately impaired ability to make decisions related to tasks of daily life, and a decreased ability to make self understood or to understand others. The Care Plan, last revised 7/13/13, directed staff "Resident is incontinent of bowel and bladder. Wears incontinent product to maintain dignity, protect clothing. Staff changes resident after incontinent episodes, completes pericare with all changes. Resident is checked q 2h and prn. Resident will also indicate a need to be changed by pointing at or grabbing crotch." Goals included, "Resident will have no skin breakdown r/t [related to] incontinence x 90 days." Interventions included, "Use of briefs/pads for incontinence protection." On 7/31/13, R3 was observed finishing breakfast in the dining room at 8:12 a.m., then wheeling himsef away from the table. At 8:35 a.m. R3 was observed in his room, taking a disposable brief out of an overhead cabinet and placing it on his reclining chair. R3 remained in is room. At 9:27 a.m. the resident assessment nurse, RN-Y walked in and asked if wanted to lay down. R3 declined. The door remained open and the interaction lasted less than a minute. At 9:30 a.m. R3 rolled himself to the dining room, where he was observed to drink a sports beverage. At 9:50 a.m. a floor nurse, FN-A, asked if R3 wanted to lay down as he was leaning over the table. At 10:20 a.m. the social worker (LSW-C) sat next to	F 315		

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F 315	Continued From page 10 R3, greeted him and did some paperwork. No offer to change briefs was made. At 10:22 a.m. R3 wheeled himself to the nurse cart and got a cookie. At 10:27 a.m. R3 was in his room, calling out "hey" in a high pitch voice. At 10:50 a.m. an activity assistant (AA-B), entered the room and invited R3 to a group. No offer to toilet was made. AA-B wheeled R3 to a ball toss group. At 11:29 a.m. R3's nursing assistant, NA-Z, entered the room with a mechanical lift. R3 declined to allow surveyor to observe. At 11: 35 a.m. NA-Z reported he offered toileting to R3 "after breakfast" but R3 refused. R3 reported he did not offer R3 an opportunity to toilet again until he entered the room again at 11:29 a.m. NA-Z reported R3 was "a little" wet NA-Z reported he told a nurse about R3's refusal. Immediately following interview with NA-Z, both floor nurses, FN-A and FN-B, reported they were not aware of R3 refusing any cares that morning. FN-B reported R3 would normally grab his crotch and make a high pitch "hey, hey hey" noise when he has to be changed. FN-B reported R3 should be checked for incontinence and changed as needed every two hours. A review of the Resident Behavior Log for July, indicated R3 displayed Rejection of Care zero times. A Progress Note, dated 7/31/13 indicated "Resident denied cares" "Resident has dementia and is incontinent of B&B [bowel and bladder] and communicates needs to staff. "Resident refused repeated attempts to toilet or lay down after breakfast. NAR let writer know at 11:30." There were no other instances of rejection of care documented for July. On 8/1/13 at 8:41 a.m. the director of nursing [DON] reported that there are no written policies	F 315		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 11 related to following the care plan and handling resident refusals. DON explained aides should be following the plan of care as directed. Care plans should be developed in partnership with family and resident input after resident bowel and bladder pattern was assessed over a three day period. If residents refused cares, then staff are taught to try a different tactic, reapproach or get help from another staff person, depending on the needs of the individual resident. During continuous observation on 8/1/13, R10 was seated in the dining room from 6:45 am until 9:30 am when R10 was taken to the bedroom and was assissted to stand by one staff member for offloading and incontinence care. Nursing assistant (NA-B) acknowledged R10 required every two hour repositioning and incontinence care. R10 had creases and crevices observed to skin in buttock area from the incontinent brief and R10 was incontinent of urine. R10's care plan dated 6/26/13, diagnosis included dementia and directed staff to assist R10 to offer toileting every 2 hours, check for incontinence every two hours and provide incontinence care. When interviewed on 8/1/13, at 9:45 a.m. NA-B confirmed R10 was to recieve incontinence care every two hours and today acknowledged R10 had gone 2 hours and forty-five minutes. NA-B further revealed being assigned to another unit but had come to assist with residents who required assist after breakfast care in R10's unit.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329 Continued From page 12

unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to monitor and establish resident specific behaviors that would justify the use of an antipsychotic medication for 1 of 10 residents (R54) reviewed for unnecessary medications.

Findings include:

Current physician orders and diagnosis list for R54 were reviewed. R54 was prescribed Olanzapine (an antipsychotic) 7.5 milligrams every night. R54 had diagnosis of dementia.

F 329

F 329

- R 54 has had medication regime reviewed by psychiatrist for appropriate use of anti-psychotic medication and possibility of dose reduction.
- Other residents receiving antipsychotic medications have had their medication use reviewed to ensure they are being prescribed/used appropriately. Residents receiving antipsychotic medications have medication use reviewed quarterly by IDT.
- Licensed staff received education regarding behavior documentation as needed to capture on-going need for antipsychotic medications. Social Service staff have been educated on appropriate use of antipsychotic medications and documentation of the presence/absence of target behaviors.
- DNS/designee to do weekly audits to ensure that resident behaviors have been documented appropriately.
- The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations.
- DNS is responsible.
- Completion date: September 10, 2013

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F 329	Continued From page 13	F 329		

Both floor nurses on R54's floor, (FN)-B (FN)-C, were interviewed on 8/1/13 at 11:42 a.m. Both FN-B and FN-C described R54 as "easy going" and that he often wandered, forgot when he ate and asked repetitive questions. Occasionally he was a little resistive to incontinence changes. They described him as becoming more irritable and asking more repetitive questions about two months ago. When asked why he was prescribed olanzapine, an antipsychotic medication, FN-C responded "maybe to prevent behaviors". Neither FN-B nor FN-C could recall a time when R54 posed a harm to himself or others. Neither were aware of a description tracking R54's behaviors outside of the Resident Behavior Tracking Logs and Progress Notes.

On 8/1/13 at approximately 2:00 p.m. the social worker, (LSW)-A, reported R54 was stable now but has been aggressive in the past, particularly during the evenings. LSW-A described that the facility believed R54 may be "sundowning" (psychological phenomenon associated with increased confusion and restlessness in patients with some form of dementia)
The Most Recent Psychosocial Progress Note/Quarterly, dated 7/19/13, described the resident as "distracted and pre-occupied with what time it was as well as where he was" and "indicated that he didn't know what to do." Behavioral concerns included "Resident's behavioral pattern have remained consistent in that resident tends to become more irritable and confused during late afternoon hours" "a combination of gentle reality orientation and offering snacks has been effective with reducing resident periods of irritability." Other behaviors

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F 329	Continued From page 14 included, "showed episodes of wandering, approaches of re-direction are generally effective" The Note did indicated dose reduction was not appropriate related to olanzapine due to a history of psychosis. However, no specific psychotic behaviors that the resident had displayed currently or historically were noted, nor behaviors that showed a harm to R54 or others. A quarterly note, dated 4/23/13 indicated similar concerns related to confusion. Resident had periods, particularly during the late afternoon hours in which "becomes agitated by raising profanity because he needs to "get home." R54 was generally redirectable by asking him about home. R54 was noted as displaying "no incidents of aggression or other behavioral disturbances." No history of psychotic behaviors harming self or others was noted. A review of the Behavior Tracking Log included two entries, one on an unknown date indicating R54 was agitated due to wanting to go home and another on 7/21/13 indicating R54 refused cares and made negative comments regarding self. Target behaviors listed on the form included "Refusing cares ie (such as)changing clothes", "neg. (negative) comments re (regarding) self" and "other" A Resident Behavior Log for July indicated R54 wandered eleven times. R54 refused care twice. The June Resident Behavior Log indicated R54 wandered 30 times. R54 was noted as having verbal behavior directed toward others seven times. The May Resident Behavior Log indicated R54 wandered thirty five times, had verbal behavior directed toward others three times and a rejection of care once. The April Behavior Log indicated R54 had wandering behavior forty	F 329		

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F 329 Continued From page 15 F 329

seven times, verbal behavior directed towards others sixteen times, behavior not directed towards others once, and rejection of care once.

The Progress Notes, dated April through July 2013, described no behavior concerns.

General Physician and Nurse Practitioner Progress progress notes were reviewed for 6/24/13, 5/31/13, 4/30/13, 3/5/13, 1/28/13, 12/31/12, 11/26/12, 10/18/12 and 9/12/12 were. No behavioral concerns were noted.

Psychiatrist progress notes, dated 5/30/13, were reviewed. A note indicated "[R54] has a history of aggressive and agitated behaviors and psychosis symptoms." No specific information given as to when this history occurred or what he did that indicated he was agitated, aggressive or psychotic. The note further indicated "Nursing staff report [R54] had increased irritability and is not easily redirected. [R54] does not appear to have any specific psychotic symptoms. [R54] is no longer experiencing any problematic agitation, nor aggressive behavior as he did in the past before he was prescribed as has been taking his current psychiatric medication regiment of Citalopram 20 mg q AM (an antidepressant medication 20 milligrams every morning) and olanzapine 5 mg q hs (an antipsychotic every night)." Despite no current psychotic or aggressive behaviors a recommendation was made "Increase olanzapine to 7.5 mg q h.s to address {R54's] moodiness and irritability and to prevent emergence of psychotic symptoms and aggressive agitation. A psychiatric progress note, dated 2/12/13, indicated " [R54] has a good stable baseline and has been experiencing no recent problematic agitated or aggressive

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F 329	Continued From page 16 behaviors and has exhibited no psychotic symptoms." No past history, specific to R54 was noted related to harm to others or self related to psychosis. However, a recommendation was made to continue the use of olanzapine 5 milligrams every night. The Resident Behavior and Antipsychotic Management policy, last revised October 2009, directed staff " Antipsychotics will not be used if the only indication is one or more of the following: "wandering, poor self care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness or agitated behaviors that do not represent danger to the resident or others." "The VistaKeane Behavior/Intervention Monthly Flow Record is completed for all identified target behaviors and interventions. Each shift tracks the number of behavior episodes, interventions, outcomes and side effects." The facility "will review the behavior records at least quarterly and recommend changes for any opportunities for gradual dose reductions or changes in behavioral intervention if warranted."	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		

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F 334 Continued From page 17

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding

F 334

F334

- R 28, R45 and R34 will not be offered flu vaccination for the 2012-2013 influenza season as that influenza season is over per CDC guidelines. R28, R45 and R34 will be offered the influenza vaccinations for the 2013-2014 influenza season per policy.
- Resident medical records will be reviewed to ensure they contain documentation of having been offered/received the influenza vaccine for the 2012-2013 flu season if documentation is available and documentation entered into PointClickCare.
- Licensed staff educated regarding Influenza/Pneumoccocal Immunization Guidelines.
- DNS/designee to do weekly random chart audits to ensure the information is documented appropriately and is in the PointClickCare system.
- The results of these audits will be reviewed at the facility QAPI meeting on a monthly basis for further recommendations.
- DNS is responsible
- Completion date: September 10, 2013

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F 334	Continued From page 18 the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to find documentation influenza vaccinations were offered for the 2012-2013 influenza season to 3 of 5 residents reviewed,R28, R45 and R34. Findings include: A review of the medical record for R28, R45 and R34 revealed no evidence R28, R45 and R34 were offered the influenza vaccination during the 2012-2013 influenza season. On 8/1/13 at 4:37 p.m. the director of nursing [DON] reported she was unable to find evidence R28, R45 or R34 were offered an influenza vaccination within the 2012-2013 influenza season. The Influenza/Pneumococcal Immunization Guidelines, last revised 2013, directed staff: "3. Immunization documentation: The immunization	F 334		

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F 334	Continued From page 19 is to be entered into resident's current medical record in PCC [electronic medical record]. Document in the immunization module in PCC: The adminisration of the influenza vaccine. Documentation must include influenza vaccine administration, type of vaccine, the ate the vaccine was administered, who administered the vaccine and the lot number. If the influenza vaccine is not given due to medical contraindications. Include the specific contraindications. If the influenza vaccine is not given to a new admission due to prior administration during current season. If the resident refuses the vaccination." "Center will offer and encourage that each resident receive immunization against influenza annually, as well as a lifetime immunization against Pneumococcal disease. The immunization will be administereed unless it is medically contraindicated, the resident has already been immunized or the resident and/or repsonsible party refuses the immunization."	F 334		

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

F5394021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/30/2013

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K 000	INITIAL COMMENTS	K 000		
	FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Living Center Lynnhurst was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:		Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements PoC ok FS 9-17-13	

DC: 9-10-13

EXIT: 8-1-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 8/30/2013

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

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Living Center Lynnhurst is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1967, an addition was constructed to the northeast and was determined to be of Type II(222) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 69 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1 . The deficient practice could affect all residents, staff and visitors within the smoke compartment. Findings include: On facility tour between 09:00 AM and 01:00 PM on 07/30/2013, it was observed that the corridor doors did not fully self close and positive latch when tested in the following areas: 1) 1st floor Nursing/ Dietary Office - Storage Room 124. 2) 1st floor Soiled Linen Room 128. This deficiency was verified by facility maintenance engineer.	K 029	K 029 • 1st floor nursing/dietary office-storage room 124: • POC is to replace existing door, closer and lockset with new solid core fire rated door and hardware that is fully self close and has positive latch. • ED and FMD are responsible • Completion date: October 11, 2013. • 1st floor soiled linen room 128 • POC is to replace existing closer and lockset hardware with new hardware that is fully self close and has positive latch. • ED and FMD are responsible • Completion date: ~~October 11, 2013.~~ 9-30-13	

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4059

August 20, 2013

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5394024

Dear Mr. Carlson:

The above facility was surveyed on July 29, 2013 through August 1, 2013 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. 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,

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5394s13lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left	

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2 000	Continued From page 1 revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000	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 which 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.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the	2 555		

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2 555	Continued From page 2	2 555		

attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 1 resident (R10) in the sample who required assistance with ambulation.

Findings include:

During an observation on 7/31/13, R10 ambulated 40 feet with physical therapy in the hallway using the front wheeled walker (FWW) and stand by assistance.

When interviewed on 8/1/13, at 8:20 a.m. the physical therapist indicated R10 had been on a maintenance program since 8/23/11 according to the Maintenance Program document which contained six caregiver signatures acknowledging the instructions to walk R10 75 feet two times per day. Interviews with the day nursing assistants were conducted on 8/1/13, between 9:00 am and 9:30 am. Nursing assistants (NA)-A, NA-B, NA-C, and licensed practical nurse (LPN)-A all indicated working full time and being long term employees,and all referenced R10 walked in therapy but not on the unit in the hallway by the nursing staff. Registered nurse (RN)-A was new to the facility and was unable to find any restorative ambulation documents for R10 indicating ambulation by nursing staff in the hallway.

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2 555	Continued From page 3 R10 was assessed to require assistance to ambulate and the physician order read to ambulate 75 feet twice a day however this information was not added to the plan of care, and staff did not ambulate R10 in the hallway. The physician order directed "to walk 75 feet twice per day with FWW and assisting of 1. Follow with W/C [wheel chair}." The physical therapy maintenance program form directed caregivers to walk R10, 75 feet two times per day. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized plans related to behaviors. The Director of Nursing could randomly audit the care plan for the effectiveness of the behavior interventions TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care	2 565		

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2 565	Continued From page 4	2 565		

for 1 of 3 residents (R10) reviewed for repositioning and 2 of 3 residents (R3, R10) reviewed for urinary incontinence.

Findings include:

R10 was assessed to require assist with repositioning, and assist with toileting and did not receive assistance in accordance with the plan of care interventions.

R10's care plan dated 6/26/13, diagnosis included dementia, directed staff to assist R10 to turn, reposition, offload and check for incontinence every two hours.

During continuous observation on 8/1/13, R10 was seated in the dining room from 6:45 am until 9:30 am when R10 was taken to the bedroom and was stood with the assistance of one staff member for offload and incontinence care.

Interview on 8/1/13 with nursing assistant (NA-B) verified R10 required every two hour repositioning and incontinence care. R10 had creases and crevices to skin in buttock area from the incontinent brief and R10 had been incontinent of urine.

The facility failed to ensure the incontinence plan of care was followed for R3. R3 was not checked for incontinence or offered to be changed for three hours.

The Care Plan, last revised 7/13/13, directed staff "Resident is incontinent of bowel and bladder. Wears incontinent product to maintain dignity, protect clothing. Staff changes resident after incontinent episodes, completes pericare with all

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2 565	Continued From page 5	2 565		

changes. Resident is checked q 2h and prn. [every 2 hours and as needed] Resident will also indicate a need to be changed by pointing at or grabbing crotch." Goals included, "Resident will have no skin breakdown r/t [related to] incontinence x 90 days." Interventions included, "Use of briefs/pads for incontinence protection."

On 7/31/13, R3 was observed finishing breakfast in the dining room at 8:12 a.m., then wheeling himself away from the table. At 8:35 a.m. R3 was observed in his room, taking a disposable brief out of an overhead cabinet and placing it on his reclining chair. R3 remained in is room. At 9:27 a.m. the resident assessment nurse, (RN)-Y walked in and asked if R3 wanted to lay down. R3 declined. The door remained open and the interaction lasted less than a minute. At 9:30 a.m. R3 rolled himself to the dining room, where he was observed to drink a sports beverage. At 9:50 a.m. a floor nurse, (FN)-A, asked if R3 wanted to lay down as he was leaning over the table. At 10:20 a.m. the social worker (LSW)-C sat next to R3, greeted him and did some paperwork. No offer to change briefs was made. At 10:22 a.m. R3 wheeled himself to the nurse cart and got a cookie. At 10:27 a.m. R3 was in his room, calling out "hey" in a high pitch voice. At 10:50 a.m. an activity assistant (AA)-B, entered the room and invited R3 to a group. No offer to toilet was made. AA-B wheeled R3 to a ball toss group. At 11:29 a.m. R3's nursing assistant, (NA)-Z, entered the room with a mechanical lift. R3 declined to allow surveyor to observe.

At 11: 35 a.m. NA-Z reported he offered toileting to R3 "after breakfast" but R3 refused. R3 reported he did not offer R3 an opportunity to toilet again until he entered the room again at 11:29 a.m. NA-Z reported R3 was "a little" wet.

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2 565	Continued From page 6 NA-Z reported he told a nurse about R3's refusal. Immediately following interview with NA-Z, both floor nurses, FN-A and FN-B, reported they were not aware of R3 refusing any cares that morning. FN-B reported R3 would normally grab his crotch and make a high pitch "hey, hey hey" noise when he has to be changed. FN-B reported R3 should be checked for incontinence and changed as needed every two hours. On 8/1/13 at 8:41 a.m. the director of nursing [DON] reported that there were no written policies related to following the care plan. DON explained staff should be following the plan of care as directed. SUGGESTED METHOD OF CORRECTION: The administrator with the director of nursing or designee could review and revise resident care plans to ensure that residents receive care and services according to their assessed needs. They could educate the staff and develop a monitoring system to assure that the residents grooming needs are met. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or	2 905		

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2 905	Continued From page 7	2 905		

the physician has ordered a different interval.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R10) at risk for skin breakdown was repositioned as assessed, to minimize or prevent skin breakdown from occurring.

Findings include:

During continuous observation on 8/1/13, R10 was seated in the dining room from 6:45 am until 9:30 am when R10 was taken to the bedroom and was stood with the assistance of one staff member to offload and be repositioned. Nursing assistant (NA)-B acknowledged R10 required every two hour repositioning. Observations revealed that R10 had creases and crevices to skin in buttock area from the incontinent brief and R10 was incontinent of urine.

R10's care plan dated 6/26/13, diagnosis included dementia and directed staff to assist R10 to turn, reposition, and offload and check for incontinence every two hours.

When interviewed on 8/1/13, at 9:45 a.m. NA-B confirmed R10 was to be re-positioned every two hours and today acknowledged R10 had gone 2 hours and forty-five minutes. NA-B further revealed being assigned to another unit but had come to assist with residents who required assist after breakfast care in R10's unit.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee

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2 905	Continued From page 8 could review the pertinent policies and procedures, revise as necessary, and educate the staff related to the policies and procedures. The administrator or designee could develop policies and procedures to ensure residents receive the toileing/incontinence services based on their assessed needs, educate all appropriate staff members on the processes and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 910		

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2 910	Continued From page 9 review, the facility failed to provide 2 of 3 residents (R3, R10), with the services for toileting needs. Findings include: During a standardized initial interview on 07/30/13 at 9:13 a.m., a family member of R3, (F)-X, reported she had seen R3 sitting in wet briefs on several occassions. F-X reported R3 would not accurately report if he needed to be changed, due to not wanting to bother staff. F-X reported she visisted on a regular basis and was familiar with R3's lifestyle and routine prior to entering the facility. A review of R3's care area assessment (CAA), dated 7/19/12, indicated R3 was always incontinent of urine and required extensive assistance with toileting. The CAA read "Resident is incontinent of bowel and bladder. Wears incontinent product to maintain dignity, protect skin and clothing. Resident checked q2h [every 2 hours] and prn [as needed]. Able to notify staff after incontinent episodes. Dependent on staff for changes. Pericare completed with all changes." A section entitled Resident and/or Family Representative directed staff "Provide input from resident and/or family representative regarding this care area. (Questions/Comments/Concerns/Preferenes/Suggestions)" The section was left blank. Informatin regarding family input was not provided in the Urinary Incontinence and Indwelling Catheter CAA. The Cognitive Loss/Delirium CAA, dated 7/19/2013, indicated R3 had short and long term memory problems, moderately impaired ability to make decisions related to tasks of daily life, and a decreased ability to make self understood or to understand others.	2 910		

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2 910	Continued From page 10	2 910		

The Care Plan, last revised 7/13/13, directed staff "Resident is incontinent of bowel and bladder. Wears incontinent product to maintain dignity, protect clothing. Staff changes resident after incontinent episodes, completes pericare with all changes. Resident is checked q 2h and prn. Resident will also indicate a need to be changed by pointing at or grabbing crotch." Goals included, "Resident will have no skin breakdown r/t [related to] incontinence x 90 days." Interventions included, "Use of briefs/pads for incontinence protection."

On 7/31/13, R3 was observed finishing breakfast in the dining room at 8:12 a.m., then wheeling himsef away from the table. At 8:35 a.m. R3 was observed in his room, taking a disposable brief out of an overhead cabinet and placing it on his reclining chair. R3 remained in is room. At 9:27 a.m. the resident assessment nurse, RN-Y walked in and asked if wanted to lay down. R3 declined. The door remained open and the interaction lasted less than a minute. At 9:30 a.m. R3 rolled himself to the dining room, where he was observed to drink a sports beverage. At 9:50 a.m. a floor nurse, FN-A, asked if R3 wanted to lay down as he was leaning over the table. At 10:20 a.m. the social worker (LSW-C) sat next to R3, greeted him and did some paperwork. No offer to change briefs was made. At 10:22 a.m. R3 wheeled himself to the nurse cart and got a cookie. At 10:27 a.m. R3 was in his room, calling out "hey" in a high pitch voice. At 10:50 a.m. an activity assistant (AA-B), entered the room and invited R3 to a group. No offer to toilet was made. AA-B wheeled R3 to a ball toss group. At 11:29 a.m. R3's nursing assistant, NA-Z, entered the room with a mechanical lift. R3 declined to allow surveyor to observe. At 11: 35 a.m. NA-Z

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2 910	Continued From page 11	2 910		

reported he offered toileting to R3 "after breakfast" but R3 refused. R3 reported he did not offer R3 an opportunity to toilet again until he entered the room again at 11:29 a.m. NA-Z reported R3 was "a little" wet NA-Z reported he told a nurse about R3's refusal. Immediately following interview with NA-Z, both floor nurses, FN-A and FN-B, reported they were not aware of R3 refusing any cares that morning. FN-B reported R3 would normally grab his crotch and make a high pitch "hey, hey hey" noise when he has to be changed. FN-B reported R3 should be checked for incontinence and changed as needed every two hours.

A review of the Resident Behavior Log for July, indicated R3 displayed Rejection of Care zero times. A Progress Note, dated 7/31/13 indicated "Resident denied cares" "Resident has dementia and is incontinent of B&B [bowel and bladder] and communicates needs to staff. "Resident refused repeated attempts to toilet or lay down after breakfast. NAR let writer know at 11:30." There were no other instances of rejection of care documented for July.

On 8/1/13 at 8:41 a.m. the director of nursing [DON] reported that there are no written policies related to following the care plan and handling resident refusals. DON explained aides should be following the plan of care as directed. Care plans should be developed in partnership with family and resident input after resident bowel and bladder pattern was assessed over a three day period. If residents refused cares, then staff are taught to try a different tactic, reapproach or get help from another staff person, depending on the needs of the individual resident.

During continuous observation on 8/1/13, R10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 12 was seated in the dining room from 6:45 am until 9:30 am when R10 was taken to the bedroom and was assissted to stand by one staff member for offloading and incontinence care. Nursing assistant (NA-B) acknowledged R10 required every two hour repositioning and incontinence care. R10 had creases and crevices observed to skin in buttock area from the incontinent brief and R10 was incontinent of urine. R10's care plan dated 6/26/13, diagnosis included dementia and directed staff to assist R10 to offer toileting every 2 hours, check for incontinence every two hours and provide incontinence care. When interviewed on 8/1/13, at 9:45 a.m. NA-B confirmed R10 was to recieve incontinence care every two hours and today acknowledged R10 had gone 2 hours and forty-five minutes. NA-B further revealed being assigned to another unit but had come to assist with residents who required assist after breakfast care in R10's unit. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are comprehensively assessed for incontinence. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs	2 915		

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2 915	Continued From page 13	2 915		

Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:

(1) bathe, dress, and groom;
(2) transfer and ambulate;
(3) use the toilet;
(4) eat; and
(5) use speech, language, or other functional communication systems; and

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 3 residents (R10) in the sample who were reviewed for ambulation.

Findings include:

R10's record was reviewed and indicated R10 had been assessed to require assistance to ambulate and the physician order read to ambulate 75 feet twice a day, however, this information was not added to the plan of care and staff was not ambulating10 in the hallway.

During an observation on 7/31/13, at 10:00 a.m,. R10 ambulated forty feet with physical therapy in

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2 915	Continued From page 14	2 915		

the hallway using a front wheeled walker (FWW) and stand by assistance.

When interviewed on 8/1/13, at 8:20 a.m. the physical therapist stated R10 had been on a maintenance program since 8/23/11and nursing staff were to be sure R10 walked 75 feet two times per day. The Maintenance Program document, which contained six caregiver signatures acknowledging the instructions, directed staff to walk R10 75 feet two times per day. The therapist indicated the expectation was for nursing to ambulate R10 according to the maintenance program and physician orders.

The physician order directed: "walk 75 feet twice per day with front wheeled walker (FWW) and assisting of 1. Follow with W/C [wheel chair}." The physical therapy maintenance program directed caregivers to walk R10, 75 feet two times per day. The nursing assistant ADL Flow Sheet Log addressing walk in hall was marked to indicate the activity did not occur.

Interviews with the day care givers were conducted on 8/1/13, between 9:00 am and 9:30 am. Nursing assistants (NA)-A, NA-B, NA-C, and licensed practical nurse (LPN)-A all indicated working full time and being long term employees. All referenced R10 walks in therapy but not on the unit by the nursing staff. Registered nurse (RN)-A was new to the facility and was unable to find any restorative ambulation documents for R10 indicating ambulation by nursing staff in the past quarter.

SUGGESTED METHOD FOR CORRECTION:
The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with

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2 915	Continued From page 15 ambulation. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 915		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	21535		

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by:
Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 3 residents (R10) in the sample who were reviewed for ambulation.

Findings include:

R10's record was reviewed and indicated R10 had been assessed to require assistance to ambulate and the physician order read to ambulate 75 feet twice a day, however, this information was not added to the plan of care and staff was not ambulating10 in the hallway.

During an observation on 7/31/13, at 10:00 a.m,. R10 ambulated forty feet with physical therapy in the hallway using a front wheeled walker (FWW) and stand by assistance.

When interviewed on 8/1/13, at 8:20 a.m. the physical therapist stated R10 had been on a maintenance program since 8/23/11and nursing staff were to be sure R10 walked 75 feet two times per day. The Maintenance Program document, which contained six caregiver signatures acknowledging the instructions, directed staff to walk R10 75 feet two times per day. The therapist indicated the expectation was for nursing to ambulate R10 according to the maintenance program and physician orders.

The physician order directed: "walk 75 feet twice per day with front wheeled walker (FWW) and assisting of 1. Follow with W/C [wheel chair}." The physical therapy maintenance program directed caregivers to walk R10, 75 feet two times per day. The nursing assistant ADL Flow Sheet Log addressing walk in hall was marked to

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21535	Continued From page 17 indicate the activity did not occur. Interviews with the day care givers were conducted on 8/1/13, between 9:00 am and 9:30 am. Nursing assistants (NA)-A, NA-B, NA-C, and licensed practical nurse (LPN)-A all indicated working full time and being long term employees. All referenced R10 walks in therapy but not on the unit by the nursing staff. Registered nurse (RN)-A was new to the facility and was unable to find any restorative ambulation documents for R10 indicating ambulation by nursing staff in the past quarter. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assign the interdisciplinary team to review the appropriateness of current medications for all residents, and refer any concerns to the attending physician and/or the consulting pharmacist. The quality assurance committe could randomly audit residents' drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing	21540		

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21540	Continued From page 18 home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to monitor and establish resident specific behaviors that would justify the use of an antipsychotic medication for 1 of 10 residents (R54) reviewed for unnecessary medications. Findings include: Current physician orders and diagnosis list for R54 were reviewed. R54 was prescribed Olanzapine (an antipsychotic) 7.5 milligrams every night. R54 had diagnosis of dementia. Both floor nurses on R54's floor, (FN)-B (FN)-C, were interviewed on 8/1/13 at 11:42 a.m. Both FN-B and FN-C described R54 as "easy going" and that he often wandered, forgot when he ate and asked repetitive questions. Occasionally he was a little resistive to incontinence changes. They described him as becoming more irritable	21540		

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and asking more repetitive questions about two months ago. When asked why he was prescribed olanzapine, an antipsychotic medication, FN-C responded "maybe to prevent behaviors". Neither FN-B nor FN-C could recall a time when R54 posed a harm to himself or others. Neither were aware of a description tracking R54's behaviors outside of the Resident Behavior Tracking Logs and Progress Notes.

On 8/1/13 at approximately 2:00 p.m. the social worker, (LSW)-A, reported R54 was stable now but has been aggressive in the past, particularly during the evenings. LSW-A described that the facility believed R54 may be "sundowning" (psychological phenomenon associated with increased confusion and restlessness in patients with some form of dementia)
The Most Recent Psychosocial Progress Note/Quarterly, dated 7/19/13, described the resident as "distracted and pre-occupied with what time it was as well as where he was" and "indicated that he didn't know what to do." Behavioral concerns included "Resident's behavioral pattern have remained consistent in that resident tends to become more irritable and confused during late afternoon hours" "a combination of gentle reality orientation and offering snacks has been effective with reducing resident periods of irritability." Other behaviors included, "showed episodes of wandering, approaches of re-direction are generally effective" The Note did indicated dose reduction was not appropriate related to olanzapine due to a history of psychosis. However, no specific psychotic behaviors that the resident had displayed currently or historically were noted, nor behaviors that showed a harm to R54 or others. A quarterly note, dated 4/23/13 indicated similar concerns related to confusion. Resident had periods,

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particularly during the late afternoon hours in which "becomes agitated by raising profanity because he needs to "get home." R54 was generally redirectable by asking him about home. R54 was noted as displaying "no incidents of aggression or other behavioral disturbances." No history of psychotic behaviors harming self or others was noted.

A review of the Behavior Tracking Log included two entries, one on an unknown date indicating R54 was agitated due to wanting to go home and another on 7/21/13 indicating R54 refused cares and made negative comments regarding self. Target behaviors listed on the form included "Refusing cares ie (such as)changing clothes", "neg. (negative) comments re (regarding) self" and "other"

A Resident Behavior Log for July indicated R54 wandered eleven times. R54 refused care twice. The June Resident Behavior Log indicated R54 wandered 30 times. R54 was noted as having verbal behavior directed toward others seven times. The May Resident Behavior Log indicated R54 wandered thirty five times, had verbal behavior directed toward others three times and a rejection of care once. The April Behavior Log indicated R54 had wandering behavior forty seven times, verbal behavior directed towards others sixteen times, behavior not directed towards others once, and rejection of care once.

The Progress Notes, dated April through July 2013, described no behavior concerns.

General Physician and Nurse Practitioner Progress progress notes were reviewed for 6/24/13, 5/31/13, 4/30/13, 3/5/13, 1/28/13, 12/31/12, 11/26/12, 10/18/12 and 9/12/12 were.

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21540	Continued From page 21 No behavioral concerns were noted. Psychiatrist progress notes, dated 5/30/13, were reviewed. A note indicated "[R54] has a history of aggressive and agitated behaviors and psychosis symptoms." No specific information given as to when this history occurred or what he did that indicated he was agitated, aggressive or psychotic. The note further indicated "Nursing staff report [R54] had increased irritability and is not easily redirected. [R54] does not appear to have any specific psychotic symptoms. [R54] is no longer experiencing any problematic agitation, nor aggressive behavior as he did in the past before he was prescribed as has been taking his current psychiatric medication regiment of Citalopram 20 mg q AM (an antidepressant medication 20 milligrams every morning) and olanzapine 5 mg q hs (an antipsychotic every night)." Despite no current psychotic or aggressive behaviors a recommendation was made "Increase olanzapine to 7.5 mg q h.s to address {R54's] moodiness and irritability and to prevent emergence of psychotic symptoms and aggressive agitation. A psychiatric progress note, dated 2/12/13, indicated " [R54] has a good stable baseline and has been experiencing no recent problematic agitated or aggressive behaviors and has exhibited no psychotic symptoms." No past history, specific to R54 was noted related to harm to others or self related to psychosis. However, a recommendation was made to continue the use of olanzapine 5 milligrams every night. The Resident Behavior and Antipsychotic Management policy, last revised October 2009, directed staff " Antipsychotics will not be used if the only indication is one or more of the following: "wandering, poor self care, restlessness,	21540		

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21540	Continued From page 22 impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness or agitated behaviors that do not represent danger to the resident or others." "The VistaKeane Behavior/Intervention Monthly Flow Record is completed for all identified target behaviors and interventions. Each shift tracks the number of behavior episodes, interventions, outcomes and side effects." The facility "will review the behavior records at least quarterly and recommend changes for any opportunities for gradual dose reductions or changes in behavioral intervention if warranted." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		