CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 43AH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	T I - TO BE COMP	LETED BY T	HE STAT	HE STATE SURVEY AGENCY Facility ID: 00945			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245394 2.STATE VENDOR OR MEDICAID NO. (L2) 914342400	3. NAME AND AL (L3) GOLDEN L (L4) 471 LYNNH (L5) SAINT PAU	IVINGCENTEF URST AVENUI	R - LYNNH	(L6) 55104	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 10/24/2013 (L34 8. ACCREDITATION STATUS: (L10 0 Unaccredited 1 TJC 2 AOA 3 Other (L30)		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 72 (L1) 13.Total Certified Beds	Complian B. Not in Co.		ram	And/Or Approved Waivers Of TI 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNI5. Life Safety Code * Code: A*	6. Scope of Services Limit7. Medical Director		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 72	NF ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38) (L3 16. STATE SURVEY AGENCY REMARKS (IF APPLIC See Attached Remarks		(L43)):				
17. SURVEYOR SIGNATURE Susanne Reuss, Unit Supervise	Date :	10/31/2013	(L19)	Shellae Dietrich, P			
PART II - TO	BE COMPLETED	BY HCFA RE	` ′	L OFFICE OR SINGLE ST			
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2)	RI	MPLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :		
22. ORIGINAL DATE 23. LTC AGR OF PARTICIPATION BEGINN 12/01/1986 (L24) (L41)	EEMENT 2 ING DATE	24. LTC AGREEM ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE: 27. ALTERN A. Suspe	ATIVE SANCTIONS ension of Admissions: d Suspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/00454		(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION 09/30/2013	OF APPROVAL D.	ATE (L33)	DETERMINATION APPR	ROVAL		

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00945

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.

J



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 B. Leach, Program Specialist Licensing and Certification Program

Colleen Feach

Division of Compliance Monitoring

Minnesota Department of Health

Enclosuce: Licensing and Certification File

Golden Livingcenter - Lynnhurst

Page 2

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 245394	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/23/2013
Name of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - LYNNHUR	ST	471 LYNNHURST AVENUE WE SAINT PAUL, MN 55104	ST

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	()	/ 5)	Date
ID Prefix Reg. # LSC	F0280 483.20(d)(3),		Correction Completed 09/10/2013	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 09/10/2013			F0311 483.25(a)(2)		Correction Completed 09/10/2013
ID Prefix Reg. # LSC	483.25(c)		Correction Completed 09/10/2013	ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 09/10/2013		ID Prefix Reg. #			Correction Completed 09/10/2013
ID Prefix Reg. # LSC	F0334 483.25(n)		Correction Completed 09/10/2013	Reg. #			Correction Completed		ID Prefix Reg. #			Correction Completed
ID Prefix Reg. # LSC				Reg. #					ъ "			Correction Completed
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC								
Reviewed E	су	Reviewed SR/cbl		Date: 10/31/2 Date:	Signature Signature		1602	22			Date: 09/23 Date:	3/2013
CMS RO	o Survey Con 8/1/2	npleted on			Check for any	Unco	rected Defic			Summary of 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 245394	(Y2) Multiple Con A. Building B. Wing	struction 01 - MAIN BUILDING 01	(Y3) Date of Revisit 10/24/2013
Name	e 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	(Y4) Item	(Y5)	Date	(Y4) Item	(°	Y5)	Date
		Correction			Correction				Correction
ID Prefix		Completed 09/30/2013	ID Prefix		Completed	ID Prefix			Completed
	NFPA 101								
LSC	K0029		LSC			LSC			-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix			ID Prefix	-		
Reg. # LSC			Reg. #			Reg. #			<u> </u>
		Correction			Correction				Correction
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		Correction Completed			Correction Completed				Correction Completed
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LSC			LSC			LSC _			<u> </u>
		Correction		(Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #						Reg. #			
			LSC						<u> </u>
Reviewed E	Ву	Reviewed By	Date:	Signature of Surv	/eyor:			Date:	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
State Agen	су	PS/cbl	10/31/2013		1242	24		10	0/24/2013
	Ву	Reviewed By	Date:	Signature of Surv	eyor:			Date:	
CMS RO									
Followup t	o Survey Co	-	c	heck for any Uncor	rected Defic	iencies. Was a	Summary of		
	7/30/2013		Uncorrected Deficiencies (CMS-2567) Sent to the Facility				ine i acility i	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 43AH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY TI					IE STATE SURVEY AGENCY Facility ID: 00945				
MEDICARE/MEDICAID PROVIDER NO. (L1)	(L3) G (L4) 4 7	ME AND ADDRE OLDEN LIVIN 71 LYNNHURS AINT PAUL, M	NGCENTER ST AVENUE	- LYNNH		55104	 Initial Termi Valida 	nation 4 tion 6	2 (L8) 2. Recertification 3. CHOW 5. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PR	OVIDER/SUPPLII	ER CATEGOR	Y 09 ESRD	02 (L7	7) 22 CLIA	7. On-Sit 8. Full St	e Visit 9	O. Other	
6. DATE OF SURVEY 08/01/2013 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other		/NF/Distinct 07	6 PRTF 7 X-Ray 8 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE			AR ENDING DA	TE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 72 13.Total Certified Beds 72		In Compliance W Program Requi Compliance Be1. Accep Not in Complia Requirements a	Vith irements ased On: otable POC		2. Te3. 244. 7-1	oved Waivers Of The schnical Personnel Hour RN Day RN (Rural SNF) fe Safety Code B*	6. S 7. M 8. F	quirements: cope of Services Medical Director Patient Room Size Beds/Room		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 72	19 SNF	ICF	IID		15. FACILITY		(L15)		
(L37) (L38) 16. STATE SURVEY AGENCY REMARKS (IF Al See Attached Remarks	(L39) PPLICABLE SHOW	(L42) LTC CANCELLA	(L43) ATION DATE):							
17. SURVEYOR SIGNATURE Mary Beth Lacina, HFE NE	II	Date : 09/1	17/2013	(L19)	Shellae Dietrich, Program Specialist 09/30/2013				09/30/2013	.20)
PART II	- TO BE COM	PLETED BY	HCFA RE		OFFICE O	R SINGLE STA	ATE AGEN	CY	(L	20)
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L21)	20. COMPLIA RIGHTS		CIVIL	2.	Statement of Financ Ownership/Control Both of the Above	Interest Disclos		.1513)	
	AGREEMENT GINNING DATE	Е	TC AGREEME ENDING DATE L25)		VOLUNTARY 01-Merger, Clos		_	(L30) INVOLUNTARY 05-Fail to Meet F 06-Fail to Meet A	<u>Y</u> Health/Safety	
25. LTC EXTENSION DATE: 27. AL A.	TERNATIVE SANC Suspension of Admi Rescind Suspension I	TTIONS ssions:	(L44) (L45)			luntary Termination n for Withdrawal		OTHER 07-Provider Statu 00-Active	is Change	
28. TERMINATION DATE: (L28)	00	MEDIARY/CARF		(L31)	30. REMARKS	·				
31. RO RECEIPT OF CMS-1539 (L32)	32. DETER 09/30	MINATION OF A	PPROVAL DA	TE (L33)	DETERMIN	NATION APPRO	OVAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00945

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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_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

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

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

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST APPROPRIATE (PAID REPORT OF THE PROVIDER OR SUPPLIER TAG FOOD INITIAL COMMENTS On July 29, 2013 through August 1, 2013, surveyors of this Departments 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 Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Compilation Monitoring, Licensing and Certification Programs; P.O. Box 04900, St. Paul, Minnesota Department of Health, Division of Correction of the Comprehensive care plan must be developed within 7 days after the completion of the Comprehensive assessment, prepared by an interdisciplinary learn, that includes the attending physician, a registered nurse with responsibility for the resident sections, the resident's heads, and, to the extent practicable, the participation of the Correction of the Correction of the Correction of	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST GOLDEN LIVINGCENTER - LYNNHURST SAINT PAUL, MN 55104 PRECISE OF PROVIDERS PLAN OF CORRECTION (EACH ORDERCOMENS HERE) PROCEED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) 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 dale, 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 64909, St. Paul, Minnesota 55164-090. F 280 433.20(d)(3), 483.10(k)(2) RIGHT TO SSPED PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompletent 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 assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, the resident's family or the resident's family or the resident's family or the resident, the resident's family or the resident's family or the resident, the resident's family or th		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
GOLDEN LIVINGCENTER - LYNNHURST A71 LYNHRURST AVENUE WEST SAINT PAUL, Min 56104 PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) F 900 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 Milmesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Programs: P.O. Box 64900, St. Paul, Minnesota 55164-0900. F 280 483.20(0)(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	GOLDEN LIVINGCENTER - LYNNHURST A71 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTION AND STORE PROVIDERS PLAN OF CORRECTION COMPETENCY (EACH CORRECTION COMPETENCY OF THE PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION COMPETENCY OF THE PROVIDERS PLAN OF CORRECTION COMPETENCY OF CORRECTION COMPETENCY OF COMPETENCY OF CORRECTION COMPETENCY OF CO			245394	B. WING _		08/01/2013
FREEK TAG REQUIATORY OR LSC IDENTIFYING INFORMATION) FOOD 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. F280 483.20(d)(3), 483.10(k)(2) RIGHT TO ARTICIPATE 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. 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, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of 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, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of 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, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident's team of qualified persons after each assessment.	FREEN TAG REQUIATORY OR LSC IDENTIFYING INFORMATION) 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 50-64-0900. F 280 483,20(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 famil			NNHURST		471 LYNNHURST AVENUE WEST	
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	by: LABORATORY DIRECTOR'S OR PROVIDE BUSUPPLIER BETTRESENTATIVE'S SIGNATURE TITLE (X8) DATE	SS=D	The resident has the incompetent or other incapacitated under participate in plannichanges in care and A comprehensive of within 7 days after the comprehensive assinterdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident, the resident participal representative and revised by a teach assessment. This REQUIREMENT.	eright, unless adjudged erwise found to be the laws of the State, to ing care and treatment or direatment. are plan must be developed the completion of the essment; prepared by an interest mined by the resident's needs, tracticable, the participation of sident's family or the resident's eright am of qualified persons after	9/13/13	SEP 1 1 2013 COMPLIANCE MONITORING LICENSE AND CERTIFIC	DIVISION ATION

Any desciency 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 nuising 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.

Facility ID: 00945

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction NG		E SURVEY PLETED
		245394	B. WING		08/	01/2013
GOLDEN	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION	nat .	/Y6)
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	review, the facility for 1 of 1 resident (R10 assistance with am Findings include: During an observat ambulated 40 feet to hallway using the frond stand by assist. When interviewed physical therapist in maintenance prograthe Maintenance Procontained six caregithe instructions to viday. Interviews with were conducted on 9:30 am. Nursing a NA-C, and licensed indicated working for employees, and all therapy but not on the nursing staff. Regist to the facility and we restorative ambulate indicating ambulational maintenance and the pambulate 75 feet two information was not and staff did not am. The physician order.	tion, interview and document ailed to revise the care plan for 0) in the sample who required bulation. ion on 7/31/13, R10 with physical therapy in the ont wheeled walker (FWW)	F 2	 R10 is being assisted to ambula physicians orders. R10 Care Plareviewed and updated to includ ambulation program. Residents on physician ordered maintenance programs will be rote ensure they are receiving maintenance program if indicate plans will be reviewed and revisineeded to include current maintenance programs. Nursing staff have been educate requirements to complete restore programs as ordered and mainta documentation of program complicensed staff will be educated a updating ambulation status care. DNS/Designee will complete we random audits to ensure compliate will report progress of audits to a committee. The results of these audits will be reviewed at the facility QAPI med on a monthly basis for further recommendations. DNS is responsible Completion date: September 10, 	eviewed ed. Care ed as enance d on the entive ining pletion. on plans. ekly nce and the QA	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	IPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	NNHURST		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 282	therapy maintenant caregivers to walk day. 483.20(k)(3)(ii) SEI PERSONS/PER C. The services provide must be provided by accordance with eacare. This REQUIREME by: Based on observareview, the facility for 1 of 3 residents repositioning and 2 reviewed for urinar Findings include: R10 was assessed repositioning, and receive assistance care interventions. R10's care plan dadementia, directed reposition, offload a every two hours. During continuous was seated in the center of the cente	theel chair}." The physical ce program form directed R10, 75 feet two times per RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of tion, interview and document failed to follow the plan of care (R10) reviewed for of 3 residents (R3, R10)	F 28	F 282	ance ance care in their dowing adom e sitioning be neeting	

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F 282	Continued From parent member for offload Interview on 8/1/13 verified R10 require and incontinence of crevices to skin in himontinent brief an urine. The facility failed to of care was follower for incontinence or three hours. The Care Plan, last "Resident is incontinent protect clothing. Stranges. Resident (every 2 hours and indicate a need to him grabbing crotch." Chave no skin break incontinence x 90 co "Use of briefs/pads" On 7/31/13, R3 was in the dining room stranges.	and incontinence care. with nursing assistant (NA-B) ed every two hour repositioning are. R10 had creases and outtock area from the d R10 had been incontinent of ensure the incontinence pland for R3. R3 was not checked offered to be changed for the revised 7/13/13, directed staff nent of bowel and bladder. Product to maintain dignity, affichanges resident after as, completes pericare with all is checked q 2h and prn. The as needed is Resident will also be changed by pointing at or it is included, "Resident will down r/t [related to] lays." Interventions included, for incontinence protection." In observed finishing breakfast at 8:12 a.m., then wheeling	F 2	DEFICIENCY)			
	observed in his roo out of an overhead reclining chair. R3 a.m. the resident a walked in and aske R3 declined. The d interaction lasted le R3 rolled himself to	the table. At 8:35 a.m. R3 was m, taking a disposable brief cabinet and placing it on his remained in is room. At 9:27 ssessment nurse, (RN)-Y d if R3 wanted to lay down. oor remained open and the ess than a minute. At 9:30 a.m. o the dining room, where he ink a sports beverage. At 9:50					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		E SURVEY MPLETED
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F 282	lay down as he was 10:20 a.m. the soci R3, greeted him an offer to change brie R3 wheeled himsel cookie. At 10:27 a.m. out "hey" in a high pactivity assistant (A invited R3 to a grou AA-B wheeled R3 to a.m. R3's nursing a room with a mechasurveyor to observe At 11: 35 a.m. NA-Z to R3 "after breakfareported he did not toilet again until he 11:29 a.m. NA-Z re NA-Z reported he to Immediately followifloor nurses, FN-A anot aware of R3 ref FN-B reported R3 vand make a high pine has to be chang	(FN)-A, asked if R3 wanted to be leaning over the table. At all worker (LSW)-C sat next to did did some paperwork. No offs was made. At 10:22 a.m. If to the nurse cart and got a m. R3 was in his room, calling bitch voice. At 10:50 a.m. an A)-B, entered the room and ip. No offer to toilet was made. In a ball toss group. At 11:29 ssistant, (NA)-Z, entered the nical lift. R3 declined to allow at the companion of t	F 28			
F 311	[DON] reported that related to following staff should be follodirected.	.m. the director of nursing t there were no written policies the care plan. DON explained wing the plan of care as TMENT/SERVICES TO IN ADLS	F 31	1		1
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER I LIVINGCENTER - L'			STREET ADDRESS, CITY, STATE, ZIP CODE 171 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 311	services to maintal specified in paragrams. This REQUIREME by: Based on observative, the facility care and services sample who were Findings include: R10's record was a had been assesse ambulate and the ambulate 75 feet to information was not staff was not ambulated for the hallway using a and stand by assist When interviewed physical therapist of maintenance progratiff were to be sufficiently the signatures acknown directed staff to was day. The therapist for nursing to ambulate and the signatures acknown directed staff to was day. The therapist for nursing to ambulate and the signatures acknown directed staff to was day. The therapist for nursing to ambulate and the signatures acknown directed staff to was day. The therapist for nursing to ambulate and the signatures acknown directed staff to was day. The therapist for nursing to ambulate and the signatures acknown directed staff to was day.	the appropriate treatment and in or improve his or her abilities raph (a)(1) of this section. ENT is not met as evidenced ation, interview and document failed to provide the necessary for 1 of 3 residents (R10) in the reviewed for ambulation. The eviewed and indicated R10 do to require assistance to physician order read to wice a day, however, this of added to the plan of care and ulating 10 in the hallway. The et with physical therapy in a front wheeled walker (FWW)	F 311	 R10 is being assisted to ambulate Physicians Order. R10 Care Plan 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 a revised as needed. Nursing staff have been educated requirements to complete restorat programs as ordered and maintain documentation of program comple DNS/Designee will complete were random audits of ambulation care and documentation to ensure compliance and will report progra audits to the QAPI committee. The results of these audits will be reviewed at the facility QAPI meed on a monthly basis for further recommendations. DNS is responsible Completion date: September 10, 	on the ive hing etion. ekly plans ess of	

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F 314	per day with front vassisting of 1. Folk The physical thera directed caregivers per day. The nursi Log addressing was indicate the activity. Interviews with the conducted on 8/1/am. Nursing assis licensed practical working full time a All referenced R10 unit by the nursing was new to the factorative ambulatindicating ambulatindicating ambulatinguarter. 483.25(c) TREATMEDIATE Based on the compresident, the facility who enters the factorative ambulatinguarter. Based on the compresident, the facility who enters the factorative unavoid pressure sores recompressure sores recompressure sores recompressives.	er directed: "walk 75 feet twice wheeled walker (FWW) and ow with W/C (wheel chair)." py maintenance program is to walk R10, 75 feet two times in assistant ADL Flow Sheet alk in hall was marked to y did not occur. I day care givers were 13, between 9:00 am and 9:30 stants (NA)-A, NA-B, NA-C, and nurse (LPN)-A all indicated ind being long term employees. I walks in therapy but not on the staff. Registered nurse (RN)-A cility and was unable to find any intion documents for R10 ion by nursing staff in the past MENT/SVCS TO PRESSURE SORES prehensive assessment of a y must ensure that a resident illity without pressure sores oresoressure sores unless the condition demonstrates that able; and a resident having between necessary treatment and the healing, prevent infection and	F 3			
	This REQUIREME by: Based on observa	INT is not met as evidenced ation, interview and document failed to ensure 1 of 1 resident				

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
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F 315	as assessed, to mi breakdown from or Findings include: During continuous was seated in the of 9:30 am when R10 and was stood with member to offload assistant (NA)-B are every two hour reprevealed that R10 skin in buttock area R10 was incontined. R10's care plan dadementia and direct reposition, and offleevery two hours. When interviewed confirmed R10 was hours and today are hours and forty-five revealed being assisted to assist with after breakfast care 483.25(d) NO CAT RESTORE BLADD. Based on the residuassessment, the faresident who enter indwelling catheter resident's clinical of the seater	in breakdown was repositioned nimize or prevent skin courring. observation on 8/1/13, R10 dining room from 6:45 am until was taken to the bedroom the assistance of one staff and be repositioned. Nursing cknowledged R10 required ositioning. Observations had creases and crevices to a from the incontinent brief and not of urine. Ited 6/26/13, diagnosis included oted staff to assist R10 to turn, load and check for incontinence on 8/1/13, at 9:45 a.m. NA-B is to be re-positioned every two cknowledged R10 had gone 2 eminutes. NA-B further signed to another unit but had a residents who required assist in R10's unit.		 R10 is being repositioned per Care. Other residents requiring assomething care are be assisted as indicated in their Care. Nursing staff has been educate regarding the importance of the Care Plan. DNS/Designee will conduct the weekly audits to ensure staff following the care plan in regar repositioning. The results of these audits with reviewed at the facility QAPI on a monthly basis for further recommendations. DNS is responsible Completion date: September 	istance eing Plan of ted following andom are ards to II be meeting	

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	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP C 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	ODE:	
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	treatment and ser infections and to refunction as possible. This REQUIREMID by: Based on observereview, the facility residents (R3, R1 needs. Findings include: During a standard at 9:13 a.m., a fair reported she had several occassion accurately report to not wanting to visisted on a regularity. A review of R3's odated 7/19/12, included assistance with to incontinent of uring assistance with to incontinent produskin and clothing, hours] and prn [assistance incontinent echanges. Pericare section entitled Representative distributions and sections and section entitled Representative distributions and sections and sections and sections are sections entitled Representative distributions and sections are sections are sections and sections are sections are sections and sections are section	t of bladder receives appropriate vices to prevent urinary tract restore as much normal bladder		 R3 and R10 are being to of care. Care Plans are beand revised as needed. Other residents requiring with incontinence care assisted as indicated per care plan. Education to nursing statimportance of following DNS/Designee will condive weekly audits to ensure sofollowing the toileting Continence of these audits reviewed at the facility Q on a monthly basis for furecommendations. DNS is responsible Completion date: Septential 	eing reviewed g assistance re being assessment and off regarding the the Care Plan. luct random staff are are Plans. its will be QAPI meeting orther	

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

Facility ID: 00945

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245394	B. WING	· · · · · · · · · · · · · · · · · · ·	08	3/01/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 315	Continued From p	age 9	F 3	15		:
	(Questions/Comm gestions)" The sec regarding family in Urinary Incontinent CAA. The Cognitiv 7/19/2013, indicate memory problems make decisions redecreased ability to understand others. The Care Plan, lass "Resident is incontinent protect clothing. Sincontinent episod changes. Resident will also by pointing at or grant of the continent will have to incontinence x	ents/Concerns/Preferenes/Sug- ction was left blank. Informatin put was not provided in the ce and Indwelling Catheter re Loss/Delirium CAA, dated ed R3 had short and long term , moderately impaired ability to lated to tasks of daily life, and a o make self understood or to				
	in the dining room himsef away from observed in his roo out of an overhead reclining chair. R3 a.m. the resident a walked in and asked declined. The door interaction lasted R3 rolled himself to was observed to da.m. a floor nurse, lay down as he was	as observed finishing breakfast at 8:12 a.m., then wheeling the table. At 8:35 a.m. R3 was om, taking a disposable brief a cabinet and placing it on his remained in is room. At 9:27 assessment nurse, RN-Y and if wanted to lay down. R3 remained open and the ess than a minute. At 9:30 a.m. to the dining room, where he rink a sports beverage. At 9:50 FN-A, asked if R3 wanted to s leaning over the table. At the sial worker (LSW-C) sat next to				

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION IDEN	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	1 ' '	NG		OMPLETED
	245394	B. WING	·	0	8/01/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURS	ST		STREET ADDRESS, CITY, STATE, ZIP C 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	ODE	
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R3, greeted him and did sor offer to change briefs was in R3 wheeled himself to the incookie. At 10:27 a.m. R3 was out "hey" in a high pitch voic activity assistant (AA-B), en invited R3 to a group. No of AA-B wheeled R3 to a ball to a.m. R3's nursing assistant, room with a mechanical lift. surveyor to observe. At 11: reported he offered toileting breakfast" but R3 refused. Foffer R3 an opportunity to to entered the room again at 1 reported R3 was "a little" was told a nurse about R3's refused following interview with NA-FN-A and FN-B, reported th R3 refusing any cares that in reported R3 would normally make a high pitch "hey, hey has to be changed. FN-B rechecked for incontinence ar needed every two hours. A review of the Resident Be indicated R3 displayed Rejectimes. A Progress Note, dat "Resident denied cares" "Recand is incontinent of B&B [b communicates needs to stare peated attempts to toilet of breakfast. NAR let writer knowere no other instances of indocumented for July. On 8/1/13 at 8:41 a.m. the components of the ported that there are people of the ported that there are people of the proported that the proported that there are people of the proported that th	nade. At 10:22 a.m. nurse cart and got a as in his room, calling the tendence of the total the room and fer to toilet was made. The cost of the cost o	F 3	15		

PRINTED: 09/03/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING __ B. WING 245394 08/01/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 315 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.

Each resident's drug regimen must be free from

F 329 : 483.25(I) DRUG REGIMEN IS FREE FROM

F 329

SS=D UNNECESSARY DRUGS

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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,,,	PROVIDER OR SUPPLIER	NNHURST		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 329	drug when used in duplicate therapy); without adequate mindications for its usadverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs used therapy is necessal as diagnosed and crecord; and resident drugs receive grade behavioral interventil	An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 329	 R 54 has had medication regime reviewed by psychiatrist for appropuse of anti-psychotic medication at possibility of dose reduction. Other residents receiving antipsyche medications have had their medicatuse reviewed to ensure they are be prescribed/used appropriately. Residents receiving antipsychotic medications have medication use reviewed quarterly by IDT. Licensed staff received education regarding behavior documentation needed to capture on-going need for antipsychotic medications. Social Service staff have been educated of appropriate use of antipsychotic medications and documentation of presence/absence of target behavior. DNS/designee to do weekly audits ensure that resident behaviors have documented appropriately. 	as or or the ors.	
·	by: Based on interview facility failed to mor specific behaviors tantipsychotic medic	NT is not met as evidenced and document review, the nitor and establish resident hat would justify the use of an eation for 1 of 10 residents unnecessary medications.		 The results of these audits will be reviewed at the facility QAPI mee on a monthly basis for further recommendations. DNS is responsible. Completion date: September 10, 2 	:	
	R54 were reviewed Olanzapine (an an	rders and diagnosis list for . R54 was prescribed ipsychotic) 7.5 milligrams d diagnosis of dementia.		· ; ;		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			471	REET ADDRESS, CITY, STATE, ZIP CODE I LYNNHURST AVENUE WEST INT PAUL, MN 55104		
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F 329	Continued From p	age 13	F:	329			
	were interviewed of FN-B and FN-C do and that he often wand asked repetitives a little resistive. They described his and asking more remonths ago. Whe olanzapine, an an responded "maybe FN-B nor FN-C coposed a harm to haware of a description outside of the Resand Progress Note on 8/1/13 at approverse and Progress Note on 8/1/13 at approverse of the Resand Progress Note on 8/1/13 at approverse of the Resand Progress Note on 8/1/13 at approverse of the Resand Progress Note on 8/1/13 at approverse of the Resand Progress Note on 8/1/13 at approverse of the Resand Progress Note on 8/1/13 at approverse of the Resand Progress Note on 8/1/13 at approverse of the Resand Progress Note of the Resand Prog	oximately 2:00 p.m. the social reported R54 was stable now ressive in the past, particularly gs. LSW-A described that the 54 may be "sundowning" enomenon associated with on and restlessness in patients					

Facility ID: 00945

PRINTED: 09/03/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING __ 08/01/2013 B. WING 245394 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 471 LYNNHURST AVENUE WEST **GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 329 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

	ENT OF DEFICIENCIES NOT CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) NOT CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) NOT CORRECTION (X3) NOT CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) NOT CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) NOT CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X5) NOT CORRECTION (X6) NOT CORRECT			TE SURVEY MPLETED		
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F 329	others sixteen time towards others on The Progress Note 2013, described in General Physician Progress progress 6/24/13, 5/31/13, 412/31/12, 11/26/12 No behavioral compsychiatrist progressive and aggressive and aggressive and aggressive and aggressive findicated he was apsychotic. The not staff report [R54] In not easily redirect have any specific no longer experient nor aggressive behave any specific in longer experient psychiatric Citalopram 20 mg medication 20 mill olanzapine 5 mg quight)." Despite not aggressive behavion made "Increase of address (R54's) in prevent emergenciaggressive agitatic dated 2/12/13, indistable baseline and	al behavior directed towards es, behavior not directed ce, and rejection of care once. es, dated April through July o behavior concerns. and Nurse Practitioner onces were reviewed for 1/30/13, 3/5/13, 1/28/13, 1/28/13, 1/28/13 and 9/12/12 were.	F 3	29		

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

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 329	symptoms." No par noted related to hat psychosis. Howeve	exhibited no psychotic st history, specific to R54 was rm to others or self related to er, a recommendation was he use of olanzapine 5	F 3	29			
F 334 SS=0	Management policy directed staff " Antithe only indication "wandering, poor simpaired memory, psychotic features) indifference to surrenervousness, uncobehaviors that do resident or others." Behavior/Interventicompleted for all icointerventions. Each behavior episodes side effects." The frecords at least que changes for any or reductions or chan warranted."	avior and Antipsychotic y, last revised October 2009, ipsychotics will not be used if is one or more of the following: elf care, restlessness, anxiety, depression (without), insomnia, unsociability, coundings, fidgeting, operativeness or agitated not represent danger to the '"The VistaKeane ion Monthly Flow Record is lentified target behaviors and n shift tracks the number of interventions, outcomes and racility "will review the behavior arterly and recommend oportunities for gradual dose ges in behavioral intervention if	F 3	34			
30-0	The facility must do that ensure that (i) Before offering the each resident, or the representative received.	evelop policies and procedures the influenza immunization, ne resident's legal eives education regarding the tial side effects of the					
	(ii) Each resident is	s offered an influenza	:				

Facility ID: 00945

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι'''		CONSTRUCTION		E SURVEY IPLETED
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	annually, unless the contraindicated or immunized during (iii) The resident or representative has immunization; and (iv) The resident's documentation that following: (A) That the residerepresentative was the benefits and point immunization; and (B) That the residerepresentative was the benefits and point immunization; and (B) That the residerepresentative that ensure that— (i) Before offering the benefits and point immunization, each legal representative the benefits and point immunization; (ii) Each resident is immunization, unlemedically contrained already been immunization; and (iv) The resident or representative has immunization; and (iv) The resident's adocumentation that following: (A) That the resident or representation that following: (A) That the resident or representation that following: (B) That the resident's adocumentation that following: (B) That the resident's adocumentation that following: (C) That the resident or representative has immunization; and (iv) The resident's adocumentation that following: (C) That the resident's adocumentation that following: (E) That the resident or representative has immunization; and (iv) The resident's adocumentation that following: (E) That the resident or representative has immunization; and (iv) The resident's adocumentation that following: (E) That the resident or representative has immunization; and (iv) The resident's adocumentation that following: (E) That the resident or representative has immunization; and (iv) The resident's adocumentation that following: (E) That the resident or representative has immunization; and (iv) The resident's adocumentation that following:	ber 1 through March 31 e immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse medical record includes t indicates, at a minimum, the ent or resident's legal provided education regarding pential side effects of influenza ent either received the ation or did not receive the ation due to medical r refusal. evelop policies and procedures the pneumococcal r resident, or the resident's e receives education regarding otential side effects of the coffered a pneumococcal ses the immunization is licated or the resident has	F3		 R 28, R45 and R34 will not be of flu vaccination for the 2012-2013 influenza season as that influenza season is over per CDC guideline R28, R45 and R34 will be offered influenza vaccinations for the 2012-2014 influenza season per policy. Resident medical records will be reviewed to ensure they contain documentation of having been offered/received the influenza vac for the 2012-2013 flu season if documentation entered into PointClickCare. Licensed staff educated regarding Influenza/Pneumoccoccal Immun Guidelines. DNS/designee to do weekly randochart audits to ensure the informat documented appropriately and is in PointClickCare system. The results of these audits will be reviewed at the facility QAPI meeton a monthly basis for further recommendations. DNS is responsible Completion date: September 10, 2 	tication is in the	

PRINTED: 09/03/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING _ 245394 B. WING 08/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ın (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 334 Continued From page 18 F 334 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.

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

The Influenza/Pneumococcal Immunization Guidelines, last revised 2013, directed staff: "3. Immunization documentation: The immunization

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCIES (EACH DEPICIENCIES) (EACH DEPICIENCY MUST BE PRECEDED BY FULL REDULATIONY OR LSC IDENTIFY INC. INC. MISSER PROCEDED BY FULL REDULATIONY OR LSC IDENTIFY INC. INC. MISSER PROVIDER BY LAND FOORRECTIVE ACTION SHOULD BE CROSS-REPERRADED TO THE APPROPRIATE DOCUMENT IN THE INFORMATION) F 334 Continued From page 19 is to be entered into resident's current medical record in PCC; The administration module in PCC; The administration, type of vaccine, the ate the vaccine was administered, who administered the vaccine was administered, the administered the vaccine and the lot number. 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 recoive immunization against influenza munally, as well as a lifetime immunization against phenomeococal disease. The immunization during current season. If the endines is the encourage that each resident receive immunization against influenza to the resident has already been immunized or the resident has already been immunized to rich resident has already been immunized to rich resident and/or repsonsible party refuses the immunization."	4	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST PREFIX TAG CAO, ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 334 Continued From page 19 Is to be entered into resident's current medical record in PCC [electronic medical record in PCC] [electronic medical record]. Document in the immunization module in PCC: The administration, type of vaccine, administration, type of vaccine, the ate the vaccine was administered, who administered the vaccine is not given to a new admission due to prior administration during current season. If the resident refuses the vacciation. "Center will offer and encourage that each resident receive immunization against influenza annually, as well as a lifetime immunization will be administered unless it is medically contraindicated, the resident has already been immunized or the resident and/or repsonsible party refuses the			245394	B. WING	•	08	/01/2013	
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 administration, type of vaccine, the ate the vaccine administration, type of vaccine, the ate the vaccine and the lot number. If the influenza vaccine contraindications. Include the specific contraindications. Include the specific contraindications. Include the specific contraindication against influenza vaccine immunization against influenza vaccine immunization against Pneumococcal disease. The immunization will be administered unless it is medically contraindicated, the resident and/or repsonsible party refuses the			NNHURST		471 LYNNHURST AVENUE WE	ZIP CODE		
is to be entered into resident's current medical record in PCC [electronic medical record]. Document in the immunization module in PCC: The administration of the influenza vaccine. Documentation must include influenza vaccine administration, type of vaccine, the ate the vaccine was administered, who administered the vaccine was administered, who administered the vaccine is not given due to medical contraindications. Include the specific 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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACCROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE		
	F 334	is to be entered into record in PCC [elect Document in the im The adminisration of Documentation must administration, type vaccine was administration, type vaccine and the lot vaccine is not given contraindications. If given to a new administration during resident refuses the offer and encourage immunization agains as a lifetime immunication as a lifetime immunication alies it is medically has already been in and/or repsonsible procuments.	o resident's current medical stronic medical record]. munization module in PCC: of the influenza vaccine. In the influenza vaccine of vaccine, the ate the stered, who administered the number. If the influenza due to medical include the specific the influenza vaccine is not ission due to prior go current season. If the vaccination." "Center will be that each resident receive st influenza annually, as well ization against Pneumococcal inization will be administereed by contraindicated, the resident inmunized or the resident	F3	34			

PRINTED: 08/20/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION SYATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245394 B. WING-07/30/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY Preparation, submission and THE FACILITY'S POC WILL SERVE AS YOUR implementation of this Plan of ALLEGATION OF COMPLIANCE UPON THE Correction does not constitute an DEPARTMENT'S ACCEPTANCE. YOUR admission of or agreement with the SIGNATURE AT THE BOTTOM OF THE FIRST facts and conclusions set forth on PAGE OF THE CMS-2567 FORM WILL BE the survey report. Our Plan of Correction is prepared and executed USED AS VERIFICATION OF COMPLIANCE. as a means to continuously improve the quality of care and to comply UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE with all applicable state and federal regulatory requirements 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. SEP PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISION HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145

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

TITLE

(X6) DATE

EXECUTIVE DIRECTOR

Facility ID: 00945

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 ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

Or by email to:

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

PRINTED: 08/20/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245394	B. WING				07/	30/2013
	PROVIDER OR SUPPLIER V LIVINGCENTER - LY	NNHURST		471 LYN	ADDRESS, CITY, STATE NHURST AVENUE WE PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD I	BE 38	(X5) COMPLETION DATE
K 000		State.mn.us and ate.mn.us RRECTION FOR EACH FINCLUDE ALL OF THE	Ko	00			1	
	to correct the deficiency. 2. The actual, or proceed as a constructed at 2 different and and a constructed at 2 different and was determined to be of 1967, an addition was northeast and was dell(222) construction. I and the 1 addition meallowed for existing because the building is automathroughout. The facilia with smoke detection open to the corridors automatic fire departress.	posed, completion date. title of the person action and monitoring to noe of the deficiency. I Lynnhurst is a 2-story I basement. The building was brent times. The original octed in 1962 and was Type II(222) construction. In s constructed to the elermined to be of Type Because the original building beet the construction type uildings, the facility was ding. I satic sprinkler protected ty has a fire alarm system in the corridors and spaces						
7	at time of the survey. The requirement at 4% NOT MET as evidenc	2 CFR, Subpart 483.70(a) is ed by:						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/20/2013 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245394 B. WING 07/30/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=E One hour fire rated construction (with 1/4 hour fire-rated doors) or an approved automatic fire K 029 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When 1st floor nursing/dietary office-storage the approved automatic fire extinguishing system. room 124: option is used, the areas are separated from POC is to replace existing door, other spaces by smoke resisting partitions and closer and lockset with new solid doors. Doors are self-closing and non-rated or core fire rated door and hardware field-applied protective plates that do not exceed that is fully self close and has 48 inches from the bottom of the door are positive latch. permitted. 19.3.2.1 ED and FMD are responsible Completion date: October 11, 2013. 1st floor soiled linen room 128 POC is to replace existing closer This STANDARD is not met as evidenced by: Based on observation, the facility failed to and lockset hardware with new hardware that is fully self close and maintain the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, has positive latch. Section 19.3.2.1. The deficient practice could ED and FMD are responsible affect all residents, staff and visitors within the Completion date: October 11, smoke compartment. 2013-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 lested in the following areas: 1) 1st floor Nursing/ Dietary Office - Storage

maintenance engineer.

2) 1st floor Soiled Linen Room 128.

This deficiency was verified by facility

Room 124.



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.

Golden Livingcenter - Lynnhurst August 20, 2013 Page 2

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

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

PRINTED: 08/20/2013 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00945 08/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

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

Minnesota Department of Health

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

TITLE (X6) DATE Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			71. BOILDING.		
		00945	B. WING		08/01/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
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2 000	validate that substa	ge 1 y may be conducted to antial compliance with the en attained in accordance with	2 000	column entitled "ID Prefix Tag." The statute/rule number and the correspond of the state statute/rule out of complished in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction or column also includes the findings win violation of the state statute after the statement, "This Rule is not met as end by." Following the surveyors finding Suggested Method of Correction and Period For Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH SUPROVIDER'S PLAN OF CORRECT THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA SUSTATUTES/RULES.	nding text iance is ne "To der. This which are he videnced gs are the the Time NING OF STATES, TION."
2 555	MN Rule 4658.0409 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555		
	must develop a cor each resident within completion of the c assessment as def comprehensive pla	elopment. A nursing home inprehensive plan of care for in seven days after the comprehensive resident ined in part 4658.0400. The in of care must be developed ary team that includes the			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DE AND PLAN OF COR			R/SUPPLIER/CLIA CATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
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attend respondappropring the respondant repression of the respondant respondant repression of the respondant respon	sident's need cable, with the sident's legal sentative. MN Requirement on observative, the facility fresident (R10 ance with amongs include: y an observative and by assistent and by assistent on the rapist in t	, a registered resident, and disciplines as, and, to the participation guardian or ent is not me on, interview ailed to revise on in the samp bulation. ion on 7/31/1 with physical ont wheeled ance. on 8/1/13, and and cated R10 am since 8/2 rogram docuriver signatur walk R10 75 or the day nure 8/1/13, betwee signature walk R10 75 or the day nure 8/1/13, betwee signature and known assistants (Nor practical nure and known assistants in the tered nurse as unable to ion documer	nd other as determined by extent nof the resident, chosen et as evidenced and document se the care plan for aple who required as a coording to the ment which research acknowledging feet two times per sing assistants are not expensed as a coording to ment which research acknowledging feet two times per sing assistants are not expensed as a coording to ment which research acknowledging feet two times per sing assistants are not expensed as a coordinate to the	2 555			

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00945	B. WING		08/0	1/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - LY	NNHIIRST	NHURST AVE AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 3	2 555			
	ambulate and the p ambulate 75 feet tw information was not	to require assistance to hysician order read to vice a day however this tadded to the plan of care, abulate R10 in the hallway.				
	twice per day with F Follow with W/C [wl therapy maintenand	r directed "to walk 75 feet FWW and assisting of 1. heel chair}." The physical be program form directed R10, 75 feet two times per				
	The Director of Nur for the licensed staf developing individua behaviors. The Dire	THOD FOR CORRECTION: sing could provide education ff regarding the importance of alized plans related to ector of Nursing could care plan for the effectiveness rventions				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to follow the plan of care				

Minnesota Department of Health STATE FORM

43AH11 If continuation sheet 4 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00945	B. WING		08/	01/2013
	PROVIDER OR SUPPLIER	NNHURST 471 LYN	ADDRESS, CITY, S INHURST AVE PAUL, MN 551	NUE WEST		
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2 565	for 1 of 3 residents repositioning and 2 reviewed for urinary Findings include: R10 was assessed repositioning, and receive assistance care interventions. R10's care plan dat dementia, directed reposition, offload a every two hours. During continuous of was seated in the design and was stood with member for offload. Interview on 8/1/13 verified R10 requires and incontinence can crevices to skin in bincontinent brief and urine. The facility failed to of care was follower for incontinence or three hours. The Care Plan, last "Resident is incontinent protect clothing. State of the sta	(R10) reviewed for of 3 residents (R3, R10)	fed d d d d d d d d d d d d d d d d d d			

Minnesota Department of Health

STATE FORM 6899 43AH11 If continuation sheet 5 of 23

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.23.110.1			
		00945	B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LY	NNHIIRST	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	changes. Resident [every 2 hours and indicate a need to be grabbing crotch." Ghave no skin break incontinence x 90 co. "Use of briefs/pads On 7/31/13, R3 was in the dining room a himself away from observed in his roo out of an overhead reclining chair. R3 is a.m. the resident as walked in and aske R3 declined. The dinteraction lasted le R3 rolled himself to was observed to dra.m. a floor nurse, lay down as he was 10:20 a.m. the soci R3, greeted him an offer to change brie R3 wheeled himsel cookie. At 10:27 a.i out "hey" in a high pactivity assistant (A invited R3 to a group AA-B wheeled R3 to a group activity assistant (A invited	is checked q 2h and prn. as needed] Resident will also be changed by pointing at or loals included, "Resident will down r/t [related to] lays." Interventions included, for incontinence protection." Is observed finishing breakfast at 8:12 a.m., then wheeling the table. At 8:35 a.m. R3 was m, taking a disposable brief cabinet and placing it on his remained in is room. At 9:27 seessment nurse, (RN)-Y dif R3 wanted to lay down. oor remained open and the loss than a minute. At 9:30 a.m. of the dining room, where he link a sports beverage. At 9:50 (FN)-A, asked if R3 wanted to be leaning over the table. At all worker (LSW)-C sat next to did did some paperwork. No less was made. At 10:22 a.m. of to the nurse cart and got a loss made. At 10:50 a.m. an laybe, entered the room and laybe. No offer to toilet was made. of a ball toss group. At 11:29 lessistant, (NA)-Z, entered the nical lift. R3 declined to allow	2 565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00945		B. WING		08/0	01/2013
	PROVIDER OR SUPPLIER	NNHURST	471 LYNN	DRESS, CITY, S HURST AVE UL, MN 551			
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2 565	NA-Z reported he to Immediately following floor nurses, FN-A and aware of R3 ref FN-B reported R3 wand make a high pinhe has to be chang be checked for inconeeded every two homeons of the following staff should be followed should be should should be should should should should be should s	old a nurse about any interview with and FN-B, report using any cares would normally getch "hey, hey he ed. FN-B reported on tinence and change in the care plan. Dowing the plan of THOD OF CORF	NA-Z, both ted they were that morning. rab his crotch y" noise when ed R3 should langed as of nursing written policies ON explained care as	2 565			
2 905	The administrator widesignee could reviplans to ensure that services according. They could educate monitoring system is grooming needs and TIME PERIOD FOR (21) days. MN Rule 4658.0528 Subp. 4. Positionin positioned in good is of residents unable must be changed as	ew and revise ret residents receit to their assesse the staff and deto assure that the met. R CORRECTION S Subp. 4 Rehabords Residents moody alignment, to change their	esident care ve care and d needs. evelop a e residents Twenty one - Positioning ust be The position own position	2 905			
	must be changed a including periods of been put to bed for has documented th hours during this tin	time after the re the night, unless at repositioning	esident has the physician every two				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` '	E CONSTRUCTION		E SURVEY PLETED
		00945		B. WING		08/	01/2013
NAME OF	PROVIDER OR SUPPLIER	•	REET ADD	DRESS, CITY, S	STATE, ZIP CODE	1 00/	01/2010
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2 905	Continued From pa	ige 7		2 905			
	the physician has ordered a different interval.		ıl.				
	by: Based on observati review, the facility f (R10) at risk for ski as assessed, to min breakdown from oc Findings include:	ū	ent sident tioned				
	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.						
	dementia and direc	ted 6/26/13, diagnosis inc ted staff to assist R10 to pad and check for inconti	turn,				
	confirmed R10 was hours and today ac hours and forty-five revealed being ass	on 8/1/13, at 9:45 a.m. Note to be re-positioned ever knowledged R10 had go e minutes. NA-B further igned to another unit but residents who required a e in R10's unit.	ry two one 2 had				
		THOD OF CORRECTION to rot of nursing, or designe					

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00945	B. WING		08/	01/2013
	PROVIDER OR SUPPLIER	NNHURST 471 L	T ADDRESS, CITY, S YNNHURST AVE T PAUL, MN 551	NUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 905	could review the pe procedures, revise the staff related to t The administrator o policies and proced receive the toileing/ on their assessed n staff members on th monitoring systems compliance.	rtinent policies and as necessary, and educate he policies and procedures or designee could develop lures to ensure residents incontinence services base needs, educate all appropriate processes and develop	ed ate			
2 910	Incontinence Subp. 5. Incontiner have a continuous properties and to recommend to recommend the summan and the summan and the summan and the summan and the summan are sum	nce. A nursing home must program of bowel and blade fuce incontinence and the fatheters. Based on the ident assessment, a nursin that: ho enters a nursing home g catheter is not catheteriz s clinical condition indicate was necessary; and no is incontinent of bladder treatment and services to treatment and to restore er function as possible.	g ed s			
	by:	ent is not met as evidence on, interview and documen				

	NT OF DEFICIENCIES OF CORRECTION		N/SUPPLIER/CLIA ATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BOILDING.			
		00945		B. WING		08/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHURST		HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 9		2 910			
	review, the facility failed to provide 2 of 3 residents (R3, R10), with the services for toileting needs.						
	Findings include:						
	During a standardiz at 9:13 a.m., a fami reported she had so several occassions accurately report if to not wanting to be visisted on a regula R3's lifestyle and re- facility.	ily member of een R3 sitting . F-X reported he needed to other staff. F-) ir basis and w	R3, (F)-X, in wet briefs on d R3 would not be changed, due K reported she vas familiar with				
	A review of R3's cadated 7/19/12, indicincontinent of urine assistance with toile is incontinent product skin and clothing. Fhours] and prn [as after incontinent epchanges. Pericare esection entitled Res Representative dire resident and/or familis care area. (Questions/Commegestions)" The sect regarding family inpurinary Incontinent CAA. The Cognitive 7/19/2013, indicate memory problems, make decisions reladecreased ability to understand others.	cated R3 was and required eting. The CA wel and bladd to maintain desident checheeded]. Able isodes. Dependent and/or lected staff "Profily representation was left bout was not profile and Indwelle Loss/Delirium draft and sho moderately in ated to tasks."	always extensive A read "Resident ler. Wears ignity, protect ked q2h [every 2 to notify staff ndent on staff for th all changes." A Family ovide input from ative regarding s/Preferenes/Sug lank. Informatin ovided in the ling Catheter m CAA, dated rt and long term npaired ability to of daily life, and a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00945	B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LY	NNHIIRST	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 10	2 910			
	The Care Plan, last "Resident is inconti Wears incontinent protect clothing. Staincontinent episode changes. Resident Resident will also in by pointing at or gra "Resident will have to] incontinence x 9 included, "Use of biprotection." On 7/31/13, R3 was in the dining room a himsef away from tobserved in his roo out of an overhead reclining chair. R3 ra.m. the resident as walked in and asked declined. The door interaction lasted le R3 rolled himself to was observed to dra.m. a floor nurse, lay down as he was 10:20 a.m. the soci R3, greeted him an offer to change brie R3 wheeled himself cookie. At 10:27 a.rout "hey" in a high p	revised 7/13/13, directed staff nent of bowel and bladder. broduct to maintain dignity, aff changes resident after s, completes pericare with all is checked q 2h and prn. Indicate a need to be changed abbing crotch." Goals included, no skin breakdown r/t [related 0 days." Interventions riefs/pads for incontinence sobserved finishing breakfast at 8:12 a.m., then wheeling the table. At 8:35 a.m. R3 was m, taking a disposable brief cabinet and placing it on his remained in is room. At 9:27 resessment nurse, RN-Y diff wanted to lay down. R3 remained open and the lass than a minute. At 9:30 a.m. the dining room, where he lank a sports beverage. At 9:50 FN-A, asked if R3 wanted to be leaning over the table. At all worker (LSW-C) sat next to did some paperwork. No lefs was made. At 10:22 a.m. for the nurse cart and got a m. R3 was in his room, calling bitch voice. At 10:50 a.m. an A-B), entered the room and				
	AA-B wheeled R3 to a.m. R3's nursing a room with a mecha	p. No offer to toilet was made. o a ball toss group. At 11:29 ssistant, NA-Z, entered the nical lift. R3 declined to allow a. At 11:35 a.m. NA-Z				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00945	B. WING		08/0	1/2013
	PROVIDER OR SUPPLIER	NNHURST 471 LYNN	DRESS, CITY, SIHURST AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	reported he offered breakfast" but R3 re offer R3 an opportuentered the room at reported R3 was "at told a nurse about Ffollowing interview of FN-A and FN-B, reported R3 would make a high pitch "has to be changed. Checked for incontinueded every two has to be changed. Checked for incontinueded every two has a Progress Normalization of the Resindicated R3 displaytimes. A Progress Normalization Resident denied cand is incontinent of communicates need repeated attempts to breakfast. NAR let were no other instandocumented for Jului On 8/1/13 at 8:41 at [DON] reported that related to following resident refusals. Do following the plan of should be developed and resident input a bladder pattern was period. If residents taught to try a differ help from another should of the individual red to the individual red to following the plan of the individual red to the red	toileting to R3 "after efused. R3 reported he did not nity to toilet again until he gain at 11:29 a.m. NA-Z little" wet NA-Z reported he R3's refusal. Immediately with NA-Z, both floor nurses, ported they were not aware of res that morning. FN-B normally grab his crotch and hey, hey hey" noise when he FN-B reported R3 should be nence and changed as rours. ident Behavior Log for July, yed Rejection of Care zero lote, dated 7/31/13 indicated ares" "Resident has dementia f B&B [bowel and bladder] and ds to staff. "Resident refused to toilet or lay down after writer know at 11:30." There nees of rejection of care y. .m. the director of nursing at there are no written policies the care plan and handling ON explained aides should be f care as directed. Care plans and in partnership with family after resident bowel and assessed over a three day refused cares, then staff are ent tactic, reapproach or get taff person, depending on the				

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	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00945	B. WING		08/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHURST	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	was seated in the depict of th	lining room from 6:45 am until was taken to the bedroom to stand by one staff member acontinence care. Nursing sknowledged R10 required esitioning and incontinence ses and crevices observed to a from the incontinent brief and at of urine. Led 6/26/13, diagnosis included ted staff to assist R10 to offer urs, check for incontinence de provide incontinence care. Led 6/26/13, diagnosis included ted staff to assist R10 to offer urs, check for incontinence de provide incontinence care de today acknowledged R10 and forty-five minutes. NA-B ing assigned to another unit sist with residents who re breakfast care in R10's unit. THOD OF CORRECTION: The per designee could develop lures to ensure residents are assessed for incontinence. The or designee could educate all embers and develop	2 910			
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	PLETED
		00945	B. WING		08/0	01/2013
	PROVIDER OR SUPPLIER	NNHLIRST 471 LYNN	DRESS, CITY, SIHURST AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and servabilities in activities deterioration is a not the resident's condipart, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	of daily living. Based on the ident assessment, a nursing that: given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this illy living includes the	2 915			
	by: Based on observati review, the facility for care and services for sample who were referred. R10's record was reflected been assessed ambulate and the pambulate 75 feet two information was not staff was not ambulate.	ent is not met as evidenced on, interview and document ailed to provide the necessary or 1 of 3 residents (R10) in the eviewed for ambulation. eviewed and indicated R10 I to require assistance to hysician order read to vice a day, however, this added to the plan of care and lating10 in the hallway. I to non 7/31/13, at 10:00 a.m,. The province of the plan of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00945	B. WING		08/0	01/2013
	PROVIDER OR SUPPLIER	NNHURST 471 LYNN	DRESS, CITY, S HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	the hallway using a and stand by assist When interviewed ophysical therapist s maintenance prograstaff were to be sur times per day. The document, which cosignatures acknowl directed staff to waday. The therapist i for nursing to ambumaintenance progration or the physician orde per day with front wassisting of 1. Folloon The physical therapidirected caregivers per day. The nursing Log addressing wall indicate the activity. Interviews with the conducted on 8/1/1 am. Nursing assist licensed practical in working full time and All referenced R10 unit by the nursing was new to the faci restorative ambulating ambulating quarter. SUGGESTED MET	front wheeled walker (FWW) ance. on 8/1/13, at 8:20 a.m. the tated R10 had been on a am since 8/23/11and nursing e R10 walked 75 feet two Maintenance Program ontained six caregiver edging the instructions, alk R10 75 feet two times per ndicated the expectation was allate R10 according to the am and physician orders. If directed: "walk 75 feet twice theeled walker (FWW) and tw with W/C [wheel chair}." by maintenance program to walk R10, 75 feet two times ag assistant ADL Flow Sheet lk in hall was marked to did not occur. If day care givers were 3, between 9:00 am and 9:30 ants (NA)-A, NA-B, NA-C, and urse (LPN)-A all indicated d being long term employees. walks in therapy but not on the staff. Registered nurse (RN)-A lity and was unable to find any ion documents for R10 on by nursing staff in the past	2 915			
	The DON or design	nee(s) could review and revise olicies and procedures				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00945	B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST			HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 915 21535	ambulation. The D provide training for policies and proced documentation. The monitor to assure a adequate and approximate PERIOD FOR (21) Days.	ON or designee (s) could all appropriate staff on these lures and importance of a DON or designee (s) could ll residents are receiving	2 915 21535			
	Subpart 1. General must be free from unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without adece D. in the prese which indicate the ediscontinued. In addition to the discontinued.	al. A resident's drug regimen unnecessary drugs. An any drug when used: dose, including duplicate drug e duration; quate indications for its use; or note of adverse consequences dose should be reduced or rug regimen review required in a nursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, sing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan the Law Library. It is not				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00945	B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/0	1/2010
		471 I VNN	HURST AVE			
GOLDEN	I LIVINGCENTER - LY	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 16	21535			
	review, the facility for care and services for	ion, interview and document ailed to provide the necessary or 1 of 3 residents (R10) in the eviewed for ambulation.				
	had been assessed ambulate and the p ambulate 75 feet tw information was no	eviewed and indicated R10 d to require assistance to shysician order read to vice a day, however, this t added to the plan of care and lating10 in the hallway.				
	R10 ambulated fort	ion on 7/31/13, at 10:00 a.m,. y feet with physical therapy in front wheeled walker (FWW) ance.				
	physical therapist s maintenance progra staff were to be sur times per day. The document, which co signatures acknowl directed staff to wa day. The therapist i for nursing to ambu	on 8/1/13, at 8:20 a.m. the tated R10 had been on a am since 8/23/11and nursing to R10 walked 75 feet two Maintenance Program ontained six caregiver edging the instructions, alk R10 75 feet two times per ndicated the expectation was alate R10 according to the am and physician orders.				
	per day with front w assisting of 1. Follo The physical therap directed caregivers per day. The nursin	r directed: "walk 75 feet twice wheeled walker (FWW) and www. www. www. www. www. www. www. ww				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00945	B. WING		08/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	1 5575	0.0
GOLDEN	GOLDEN LIVINGCENTER - LYNNHURST 471 LYN SAINT F			NUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	indicate the activity Interviews with the conducted on 8/1/1; am. Nursing assist licensed practical neworking full time an All referenced R10 unit by the nursing swas new to the facil restorative ambulat					
	The Director of Nur- interdisciplinary tea appropriateness of residents, and refer physician and/or the quality assurance of	THOD FOR CORRECTION: sing could assign the m to review the current medications for all rany concerns to the attending e consulting pharmacist. The ommitte could randomly audit mens to ensure compliance.				
	(21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1315 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the physician. If the attending concur with the nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	NNHURST 471	EET ADDRESS, CITY, S' LYNNHURST AVEN	NUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21540	home's recommend adequate justification believes the resider adversely affected, matter to the medical director is a the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician directly to the QAA.	dation, or does not providen, and the pharmacist of the pharmacist must refer all director for review if the not the attending physicial of determines that the attendance adequate justification attending physician does not matter must be referred y Assurance and Assessive quired by part 4658.007 ician is the medical direct macist shall refer the material direct ma	er the e in. If inding on for s not ed for ment 0. If iter.			
	by: Based on interview facility failed to mor specific behaviors t antipsychotic medic (R54) reviewed for Findings include: Current physician o R54 were reviewed Olanzapine (an antievery night. R54 ha Both floor nurses of were interviewed or FN-B and FN-C des and that he often w and asked repetitive was a little resistive	and document review, the sitor and establish resider hat would justify the use eation for 1 of 10 resident unnecessary medications rders and diagnosis list for the station for 1 of 10 resident unnecessary medications rders and diagnosis list for the state of the st	of an s s. or s N)-C, th ng" ate / he s.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING:			
		00945		B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LY	NNHURST		HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From parand asking more remonths ago. When olanzapine, an antipersponded "maybe FN-B nor FN-C couposed a harm to his aware of a descript outside of the Resident Progress Note: On 8/1/13 at approximate approximate approximate related of psychological phenincreased confusion with some form of a continued that he described behavioral concerns behavioral pattern that resident tends confused during lat combination of genoffering snacks has resident periods of included, "showed approaches of red The Note did indicated that the recurrently or historic that showed a harm note, dated 4/23/13 related to confusion."	petitive question asked why her posychotic mediator prevent behald recall a time moself or others ion tracking. Reported R54 was sive in the passive in the dand pre-one well as where idn't know what is included "Repassive remained to become more afternoon hother reality orients been effective irritability." Other pisodes of was irrection are gented dose reductor olanzapine ever, no specifically were noted in to R54 or other indicated similar in the passive irritability.	was prescribed ication, FN-C naviors". Neither when R54 s. Neither were 54's behaviors Tracking Logs o.m. the social as stable now ast, particularly ribed that the downing" ciated with ness in patients rogress scribed the cupied with he was" and at to do." esident's a consistent in the irritable and fours" "a station and e with reducing the behaviors andering, merally effective ction was not due to a history of psychotic splayed d, nor behaviors ers. A quarterly ilar concerns	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00945	B. WING		08/	01/2013
	PROVIDER OR SUPPLIER	NNHURST 471 LYN	DDRESS, CITY, S' NHURST AVEN AUL, MN 551(NUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	particularly during the which "becomes ag because he needs generally redirectate R54 was noted as aggression or other history of psychotic others was noted. A review of the Behtwo entries, one on R54 was agitated danother on 7/21/13 and made negative Target behaviors lis "Refusing cares ie "neg. (negative) con and "other" A Resident Behavior wandered eleven the June Resident wandered 30 times verbal behavior directed to rejection of care on indicated R54 had waven times, verbal others sixteen times towards others oncome The Progress Notes 2013, described no General Physician a Progress progress 6/24/13, 5/31/13, 4/3/31/31/13, 4/3/31/13, 4/3/31/13, 4/3/31/13, 4/3/31/13, 4/3/31/13, 4/3/31/31/31/	the late afternoon hours in pitated by raising profanity to "get home." R54 was ble by asking him about home displaying "no incidents of behavioral disturbances." No behaviors harming self or avior Tracking Log included an unknown date indicating ue to wanting to go home and indicating R54 refused cares comments regarding self. Sted on the form included (such as)changing clothes", mments re (regarding) self. The self-area of the form included (such as)changing clothes. R54 refused care twice. Behavior Log indicated R54. R54 was noted as having ected toward others seven sident Behavior Log indicated by five times, had verbal oward others three times and ce. The April Behavior Log wandering behavior forty behavior directed towards so, behavior not directed e, and rejection of care once. So, dated April through July behavior concerns. and Nurse Practitioner notes were reviewed for (30/13, 3/5/13, 1/28/13, 10/18/12 and 9/12/12 were.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00945	B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHIIRSI	IHURST AVE NUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 21	21540			
	No behavioral cond	erns were noted.				
	reviewed. A note in aggressive and agi symptoms." No spewhen this history or indicated he was ag psychotic. The note staff report [R54] had not easily redirecte have any specific proposition of longer experient or aggressive behavior aggressive behavior and aggressive behavior and "Increase ola address (R54's) made "Increase ola address (R54's) morevent emergence aggressive agitation dated 2/12/13, indicated 2/12/13, indicated 2/12/13, indicated to behaviors and has symptoms." No passon the distribution of the Resident Behamangement policy directed staff "Antithe only indication in the symptoms of the symptoms of the symptoms of the symptoms of the symptoms."	as notes, dated 5/30/13, were dicated "[R54] has a history of tated behaviors and psychosis edific information given as to occurred or what he did that gitated, aggressive or a further indicated "Nursing ad increased irritability and is d. [R54] does not appear to sychotic symptoms. [R54] is being any problematic agitation, avior as he did in the past cribed as has been taking his medication regiment of a AM (an antidepressant grams every morning) and his (an antipsychotic every current psychotic or or a recommendation was anzapine to 7.5 mg q h.s to codiness and irritability and to be of psychotic symptoms and in. A psychiatric progress note, cated "[R54] has a good I has been experiencing no agitated or aggressive exhibited no psychotic is thistory, specific to R54 was rem to others or self related to or, a recommendation was ne use of olanzapine 5 ght. Avior and Antipsychotic (7, last revised October 2009, psychotics will not be used if sone or more of the following: leff care, restlessness,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00945	B. WING		08/0	1/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHIIRST	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	psychotic features) indifference to surre nervousness, unco behaviors that do n resident or others." Behavior/Interventic completed for all id interventions. Each behavior episodes, side effects." The frecords at least que changes for any op reductions or change warranted." SUGGESTED MET The Director of Nur develop policies an and conduct randor medication regimer state and federal residence.	anxiety, depression (without , insomnia, unsociability, bundings, fidgeting, operativeness or agitated ot represent danger to the	21540			

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