DEPARTMENT OF HEAL						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 4HCK
1. MEDICARE/MEDICAID PROVI (L1) <b>245270</b> 2.STATE VENDOR OR MEDICAII (L2) <b>823957600</b>	DER NO.	3. NAME AND AI (L3) GOLDEN L (L4) 525 BLUFF (L5) ST CHARLI	DDRESS OF FAC IVINGCENTI AVENUE	CILITY	TE SURVEY AGENCY TEWATER (L6) 55972	Facility ID: 00942         4. TYPE OF ACTION: <u>7</u> (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE OF (L9) 04/01/2006</li> <li>6. DATE OF SURVEY 09</li> <li>8. ACCREDITATION STATUS:         <ul> <li>0 Unaccredited</li> <li>1 TJC</li> <li>2 AOA</li> <li>3 Other</li> </ul> </li> </ol>	/01/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	IPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/II 12 RHC	14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
<ul> <li>11. LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	ON 55 (L18) 55 (L17)	Complianc 1. A B. Not in Con		gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
		1				
14. LTC CERTIFIED BED BREAKI		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
18 SNF 18/19 SN 55 (L37) (L38)	F 19 SNF (L39)	(L42)	(L43)		1801 (e) (1) or 1801 (j) (1):	
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Michele McFarland, HI	E NE II	0	9/22/2015	(L19)	K <u>amala Fiske-Downing.</u>	Enforcement Specialist 09/22/2015 (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIT          1. Facility is Eligible t          2. Facility is not Eligit	o Participate		IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION <b>01/01/1985</b>	BEGINNINC	<b>B</b> DATE	ENDING DA	TE	VOLUNTARY         00           01-Merger, Closure         00	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	of Full to Model Igreenent
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00454				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	LDATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245270

September 22, 2015

Ms. Margaret Holm, Administrator Golden Livingcenter - Whitewater 525 Bluff Avenue St Charles, Minnesota 55972

Dear Ms. Holm:

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 August 31, 2015 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 22, 2015

Ms. Margaret Holm, Administrator Golden Livingcenter - Whitewater 525 Bluff Avenue St Charles, MNinnesota 55972

RE: Project Number S5270024

Dear Ms. Holm:

On August 5, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective August 10, 2015. (42 CFR 488.422))

This was based on the deficiencies cited by this Department for an extended survey completed on July 17, 2015. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On September 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 31, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 17, 2015, as of August 31, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 31, 2015.

However, as we notified you in our letter of August 5, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 17, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter.

Golden Livingcenter - Whitewater September 22, 2015 Page 2

• Per instance civil money penalty of for the deficiency cited at F323, (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

#### **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 245270	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 9/1/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
G	DLDEN LIVINGCENTER - WHITEWA	TER	525 BLUFF AVENUE ST CHARLES, MN 55972	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(	Y5)	Date
ID Prefix Reg. # LSC	F0176 483.10(n)	Correction Completed 08/26/2015	ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii),		ID Prefix Reg. # LSC	F0280 483.20(d)(3), 4		_
ID Prefix		Correction Completed 08/26/2015	ID Prefix		Correction Completed 08/26/2015	ID Prefix			Correction Completed 08/26/2015
ID Prefix Reg. # LSC	F0428 483.60(c)	Correction Completed 08/26/2015	ID Prefix Reg. # LSC	F0441 483.65	Correction Completed 08/26/2015		F0465 483.70(h)		Correction Completed 08/26/2015
ID Prefix Reg. # LSC	F0497 483.75(e)(8)	Correction Completed 08/26/2015	ID Prefix Reg. # LSC	F0520 483.75(o)(1)	Correction Completed 08/26/2015	ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			
Reviewed I State Agen Reviewed I CMS RO	cy G	iewed By PN/kfd iewed By	Date: 09/22/20 Date:	Signature of Signature of Signature of	312	17		Date: 09 Date:	/01/2015
Followup t	o Survey Complet 7/17/201				ncorrected Defic Deficiencies (CM			YES	NO

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245270	(Y2) Multiple Cons A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 9/19/2015
Name of Facility			Street Address, City, State, Zip Code	
G	DLDEN LIVINGCENTER - WHITEWA	TER	525 BLUFF AVENUE ST CHARLES, MN 55972	

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)	ltem		(Y5)	Date
		Correction			C	Correction					Correction
ID Prefix		Completed 08/31/2015	ID Prefix			Completed 8/29/2015		ID Prefix			Completed 08/31/2015
-	NFPA 101		•	NFPA 101				0	NFPA 101		
LSC	K0018		LSC	K0029				LSC	K0050		
		Correction			C	Correction					Correction
ID Prefix		Completed 08/31/2015	ID Prefix			Completed 8/31/2015	1	ID Prefix			Completed
Reg. #	NFPA 101		Reg. #	NFPA 101				D //			
	K0076			K0144				LSC			
		Correction			C	Correction					Correction
ID Due fin		Completed	ID Due fee			Completed					Completed
Reg. #			Reg. #					Reg. #			
								200			
		Correction			C	Correction					Correction
ID Prefix		Completed	ID Prefix		(	Completed		ID Prefix			Completed
Reg. #											
			LSC					LSC			
		Correction			C	Correction					Correction
		Completed			(	Completed					Completed
Reg. #			Reg. #					Reg. #			
Reviewed E	By Re	viewed By	Date:	Signatur	e of Surv	evor:				Date:	
State Agen		S/kfd				-	822				09/19/2015
Reviewed E		viewed By	Date:	Signatur	e of Surv		044			Date:	
CMS RO											
Followup t	o Survey Comple 7/14/20			Check for an Uncorrect					Summary of the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 22, 2015

Ms. Margaret Holm, Administrator Golden Livingcenter - Whitewater 525 Bluff Avenue St Charles, Minnesota 55972

Re: Reinspection Results - Project Number S5270024

Dear Ms. Holm:

On September 1, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 1, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kumalu Piske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00942	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 9/1/2015	
Name of Facility			Street Address, City, State, Zip Code		
GC	DLDEN LIVINGCENTER - WHITEWA	TER	525 BLUFF AVENUE ST CHARLES, MN 55972		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	) Date	(Y4) Item		(Y5)	Date
ID Prefix	_20255 MN Rule 4658.	Correction Completed 08/26/2015	ID Prefix	_20570 MN Rule 4658.0405 Su	Correction Completed 08/26/2015		× <u>20830</u> # MN Rule 465	59 0520 8	Correction Completed 08/26/2015
0	MIN HUIE 4056.			Min hule 4058.0405 Su					
ID Prefix		Correction Completed 08/26/2015	ID Prefix Reg. #		Correction Completed 08/26/2015	ID Prefi Reg. :	x <u>21530</u> # MN Rule 465	58.1310 A	Correction Completed 08/26/2015 .B.C
	MN Rule4658.			21565 MN Rule 4658.1325 Su		Reg.	x 21665 # MN Rule 465		Correction Completed 08/26/2015
ID Prefix Reg. # LSC			Reg. #			Reg.	×		
ID Prefix Reg. # LSC			Reg. #		Correction Completed		x		Correction Completed
State Agen Reviewed B	cy (	eviewed By GPN/kfd eviewed By	Date: 09//22/20 Date:	Signature of Su	3	1217		Date: Date:	09/01/2015
	o Survey Comp 7/17/2 M: REVISIT RE	015		Check for any Unco Uncorrected Defin Page 1 of 1					NO

DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL TE SURVEY AGENCY	ID: 4HCK
					IE SUKVEI AGENCI	Facility ID: 00942
1. MEDICARE/MEDICAID PROVIDE (L1) 245270	K NU.	3. NAME AND AI (L3) GOLDEN L			TEWATER	4. TYPE OF ACTION: $\underline{2}(L8)$
2.STATE VENDOR OR MEDICAID N	0.	(L4) 525 BLUFF	AVENUE			1. Initial     2. Recertification       3. Termination     4. CHOW
(L2) <b>823957600</b>		(L5) ST CHARL	ES, MN		(L6) <b>55972</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9) <b>04/01/2006</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 07/17/	<b>2015</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		·
From (a):		A. In Complia	nce With		And/Or Approved Waivers O	f The Following Requirements:
To (b):			equirements		2. Technical Personne	_ · · · · · · · · · · · · · · · · · · ·
12.Total Facility Beds	<b>55</b> (L18)	1	e Based On:		3. 24 Hour RN 4. 7-Day RN (Rural SI	7. Medical Director
12. Iotai Facility Beus	<b>55</b> (L18)	1. A	cceptable POC		5. Life Safety Code	NF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	<b>55</b> (L17)	X B. Not in Con	npliance with Progents and/or Appli		* Code: <b>B</b> *	(L12)
		Kequitein	ents and/or Appli		* Code: <b>B</b> *	(E12)
14. LTC CERTIFIED BED BREAKDOW	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
55						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):		
17. SURVEYOR SIGNATURE						
17. SURVETOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:
Kyla Einertson, HFE NE I	I		08/25/2015	(L19)	Kamala Fiske-Downing	Enforcement Specialist 09/04/2015
PAR	T II - TO BE	COMPLETED	BY HCFA RF	· · /	L OFFICE OR SINGLE S	(L20) STATE AGENCY
19. DETERMINATION OF ELIGIBILI			IPLIANCE WITH			ancial Solvency (HCFA-2572)
			ITS ACT:	I CI VIL	2. Ownership/Contr	rol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Pa	irticipate				3. Both of the Abov	/e :
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEI	VENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	J: (L30)
OF PARTICIPATION	BEGINNINC		ENDING DA			<u>0</u> INVOLUNTARY
01/01/1985	DEGININING	DAIE	LINDING DA	IL	01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	. ,		03-Risk of Involuntary Terminati	ion OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
	B. Rescind Su	spension Date:	<i>a</i> . (5)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
	(7.90)	00454				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	PROVAL
	< = /			· · · · /	PETERMINATION ALL	110 // 1L



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted August 5, 2015

Ms. Margaret Holm, Administrator Golden Livingcenter - Whitewater 525 Bluff Avenue St Charles, Minnesota 55972

RE: Project Number S5270024

Dear Ms. Holm:

On July 17, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

### **REMOVAL OF IMMEDIATE JEOPARDY**

We also verified, on July 16, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

#### DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health Health Regulation Division 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 Telephone: (507) 206-2731 Fax: (507) 206-2711

#### **NO OPPORTUNITY TO CORRECT - REMEDIES**

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective August 10, 2015. (42 CFR 488.422)

Golden Livingcenter - Whitewater August 5, 2015 Page 3

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Per instance civil money penalty of for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

# SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Golden Livingcenter - Whitewater is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 17, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Golden Livingcenter - Whitewater August 5, 2015 Page 4

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

# ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

# 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 October 17, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

Golden Livingcenter - Whitewater August 5, 2015 Page 6

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 January 17, 2016 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Golden Livingcenter - Whitewater August 5, 2015 Page 7

### Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Katol moton

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·	FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245270	B. WING			07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER			25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FO	000			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has beet your verification sur Minnesota Departm 7/15, 7/16 and 7/17 conducted on 7/16 The survey resulted (IJ) at F323 due to implement appropria supervision, eating textured food/fluids choking/aspiration of residents (R12, R5 at risk. The immediate jeopt it was first observed the necessary super and food consistent meal service obser notified of the IJ on removed on 7/16/15 implemented a rem	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with vey was conducted by the nent of Health on 7/13, 7/14, 7/15. An extended survey was and 7/17/15. d in an Immediate Jeopardy the facility's failure to iate interventions including assistance and/or appropriate					
LABORATOR	/ / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE
	ically Signed						08/14/2015

**Electronically Signed** 

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

PRINTED: 08/19/2015

		AND HUMAN SERVICES			FORM	: 08/19/2015 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING _		07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD		
GOLDEN	LIVINGCENTER - WI	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000 F 176 SS=D	Continued From par severity level of a D with a potential for in 483.10(n) RESIDEN DRUGS IF DEEME An individual residen the interdisciplinary §483.20(d)(2)(ii), ha practice is safe. This REQUIREMEN by: Based on observation review, the facility far assessment to detect capable to self administration resident (R8) review medication. Findings Include: R8's quarterly Mining assessment dated to a having moderated daily decision making indicated the residen anxiety state. Currect on the July 2015 Market	ge 1 b, isolated, with no actual harm no more than minimal harm. NT SELF-ADMINISTER ED SAFE ent may self-administer drugs if team, as defined by as determined that this NT is not met as evidenced tion, interview and document	F 00	DEFICIENCY)	ion ermine ations. inister to be heir ability to ons is not cated on on self eted weekly ire to self tive findings	8/26/15
	was observed to be activity director (AD (RN)-B. Licensed p	ng for constipation. p.m. a cart with supper trays a taken from the kitchen by the p)-A and registered nurse ractical nurse (LPN)-A tray cart and asked which tray		-DNS/designee will be respons -Corrective action will be comp 8/26/15.		

Facility ID: 00942

If continuation sheet Page 2 of 50

		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245270	B. WING _			<b>07</b> / <sup>.</sup>	17/2015
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER		-	5 BLUFF AVENUE F CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 176	was for R8. LPN-A from R8's supper tr medication from a r chocolate milk. LPN Miralax into R8's ch the chocolate milk t tray back into the ca the medication cart medications for oth continued towards to R8 her supper tray RN-B was heard to you watch her? She RN-B returned at 7: drink her chocolate At 7:14 p.m. RN-B surveyor about whe assessed to self ad medication. R8 step immediately returne self administer." WI been an assessme administer the med know, but I'll just tal stand here." RN-B chocolate milk from On 7/13/15 at 7:30 was routine practice chocolate milk and whomever is delive will not drink it if I b way. She just gets a her." When LPN-A been assessed to s	removed the chocolate milk ray and poured powdered medication cup into the N-A verified she'd poured hocolate milk. LPN-A returned to the supper tray and put the art. LPN-A then went back to to proceed with passing er residents. AD-A and RN-B the middle hall. After delivering at approximately 7:08 p.m., ask the administrator, "can e has Miralax in that cup." :13 p.m. and prompted R8 to milk. was questioned by the ether or not R8 had been deninister the Miralax pped away for a moment and ed stating, "she has an order to hen asked whether there had nt of R8's ability to self lication, RN-B stated, "I don't ke it away so you don't have to was then observed to take the n R8. p.m. LPN-A was asked if it e to place Mirilax in R8's send the tray to her room with ring trays. "With her it is. She ring it in. We have to do it that agitated when people watch was asked whether R8 had self administer medications know, we just have to get	F 17	76			

Facility ID: 00942

If continuation sheet Page 3 of 50

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	IPLETED
		245270	B. WING _		07/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE		
GOLDEN	I LIVINGCENTER - W	HITEWATER		ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 176	On 7/13/15 at 7:38 have an assessme ability to self admin verified that it would place medication in and send with the n A Self Administratio completed for R8 o Resident/patient re- medications: 'No. N The Interdisciplinar was 5/19/14, and w	p.m. RN-A verified R8 did not nt completed to identify R8's ister medications. RN-A also d not be normal practice to to a resident's chocolate milk	F 17	76		
F 225 SS=E	The facility's policy: Adminstation-Gene dated 5/12 included person who prepare is the person who a Residents are allow medications when s attending physician procedures for self- medications." 483.13(c)(1)(ii)-(iii),	Medication eral Guidelines, Section 7.2 d: "B. Administration 5. The es the dose for administration administers the dose. 13. wed to self-administer specifically authorized by the and in accordance with -administration of (c)(2) - (4) PORT	F 22	25		8/26/15
	been found guilty or mistreating residen had a finding entered registry concerning of residents or mise and report any know court of law against	ot employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or				

Facility ID: 00942

If continuation sheet Page 4 of 50

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270	A. BUILDIN	IPLE CONSTRUCTION		E SURVEY PLETED	
	245270	B. WING _	A. BUILDING		COMPLETED	
	•			07/17/2015		
I LIVINGCENTER - W			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - WHITEWATER         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES			525 BLUFF AVENUE ST CHARLES, MN 55972			
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
other facility staff to or licensing authorit The facility must en- involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and ce The facility must ha violations are thoro prevent further pote investigation is in p The results of all in	b the State nurse aide registry ties. neure that all alleged violations eent, neglect, or abuse, i unknown source and i resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 22	25			
with State law (inclu certification agency incident, and if the appropriate correct	uding to the State survey and within 5 working days of the alleged violation is verified ive action must be taken.					
failed to ensure 5 o E3, E4, E5) had ref part of their pre-hire	f 5 new employees (E1, E2, erence checks completed as a e screening. This had the		on all new employees. -All residents have the potential affected if reference checks are completed and reviewed prior to employment.	to be not		
	other facility staff to or licensing authori The facility must er involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and co The facility must haviolations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclu- certification agency incident, and if the appropriate correct This REQUIREMEI by: Based on record ref failed to ensure 5 o E3, E4, E5) had ref part of their pre-hire potential to affect a Findings include: E1 was hired by the	other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 5 of 5 new employees (E1, E2, E3, E4, E5) had reference checks completed as a part of their pre-hire screening. This had the potential to affect all residents in the facility.	other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 5 of 5 new employees (E1, E2, E3, E4, E5) had reference checks completed as a part of their pre-hire screening. This had the potential to affect all residents in the facility. Findings include: E1 was hired by the facility as a registered nurse	other facility staff to the State nurse aide registry or licensing authorities.Image: Constant of the state nurse aide registry or licensing authorities.The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.F225 -Reference checks have been of on all new employees. -All residents have the potential affected if reference checks are completed and reviewed prior to employment. -Hiring managers have been ed reprovent.Findings include: E1 was hired by the facility as a registered nurseF225 -Reference checks are completed and reviewed prior to employment. -Hiring managers have been ed requirements for reference checks	other facility staff to the State nurse aide registry       in the facility staff to the State nurse aide registry         or licensing authorities.       The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).         The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigations in progress.         The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.         This REQUIREMENT is not met as evidenced by:       F225         Based on record review and interview, the facility failed to ensure 5 of 5 new employees (E1, E2, E3, E4, E5) had reference checks completed as a part of their pre-hire screening. This had the potential to affect all residents in the facility.         Findings include:       F1 was hired by the facility as a registered nurse	

Facility ID: 00942

If continuation sheet Page 5 of 50

						. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED	
		245270	B. WING _			/17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GOLDE	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 225	resources (HR) file 2/23/15. Upon revie although 1 work ref the RN checks 1 w documentation of a response documer was provided, no d reference check, no E2 was hired as a o to the HR file, a bac on 5/26/15, howeve received a docume clearance to work. 5/26/15. Although been crossed off, th references. E3 was hired and b assistant 6/23/15. was no documenta the box 'may we co yes or no). Howeve termination from hi voluntary. E3's file employment packe E4 was hired and b staff on 6/23/15. Ac provided 2 work ref reference, and 1 pe there was no docum had been contacted E5 was hired and b	, E1 also began orientation ew, it was noted the that ference had been provided by ork reference was listed, no attempted reference check, no need. One personal reference ocumentation of attempted or response documented. dietary staff 5/26/15. According ckground study was requested er the provider had not ented final background study E2 began orientation on a reference box in the file had here were no documented began orientation as a nursing According to the HR file, there tion of a reference check (and ontact' was not checked either er the HR file indicated E3's s previous employer was not lacked the conditional offer of	F 22	<ul> <li>-Audits of new hires will be of insure reference checks are prior to employment. Negativity will be corrected immediated reviewed at QAPI.</li> <li>-ED/designee will be responted -Corrective action will be constrained by 26/15.</li> </ul>	completed ive findings y and sible.		

If continuation sheet Page 6 of 50

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 08/19/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING		07/	/17/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER		25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225 F 280 SS=D	The facility's New H contained a new en Checklist. The form document when ref there were no other who or when refere The facility's Condit packet included refe they were either bla in but there was no anyone had been correference. On 7/17/15, at 10:2 (ED) was interviewe currently the persor resource questions employee HR files of the ED verified that not completed. infor employee files lack 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannic changes in care and A comprehensive car within 7 days after t comprehensive assis interdisciplinary tea physician, a registe for the resident, and	<ul> <li>a. A. A.</li></ul>	F 225			8/26/15

Facility ID: 00942

If continuation sheet Page 7 of 50

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		245270	B. WING		07/17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	N LIVINGCENTER - W	HITEWATER			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
F 280	and, to the extent p the resident, the re legal representative and revised by a te each assessment.	bracticable, the participation of esident's family or the resident's e; and periodically reviewed eam of qualified persons after	F 280		
	by: Based on interview facility failed to upor residents (R45) rew Findings include: R45 was discharge readmitted on 6/16 cerebral artery occ hemiplegia affectin cerebral vascular of due to stroke). Upor was not updated to status leading to a R45's 14 day Minin 6/29/15 revealed R plus person physic transfers, walking i dressing and toilet the unit required ar physical assist. Fur	ed to the hospital on 6/4/15, i/15 with primary diagnoses of lusion with infarct (stroke), ig non-dominant side due to disease (left sided weakness on readmission R45's care plan o reflect his current functioning		F280 -Plans of care has been updated for R for falls prevention. -Residents with falls have the potential be affected if care plans are not update with new interventions. -IDT has been educated on the requirements updating care plans. -Audits of care plan updates will be conducted following resident falls to insure new interventions are reflected. Negative results will be reviewed at QA -DNS/designee will be responsible. Corrective action will be completed by 8/26/15.	l to ed API.
	hemiplegia affectin cerebral vascular of due to stroke). Upo was not updated to status leading to a R45's 14 day Minin 6/29/15 revealed R plus person physic transfers, walking i dressing and toilet the unit required ar physical assist. Fur	ig non-dominant side due to disease (left sided weakness on readmission R45's care plan o reflect his current functioning fall on 6/29/15. num Data Set (MDS) dated R45 required an extensive two al assist for bed mobility, in room, personal hygiene, use. Locomotion on and off in extensive one person inctional limitation revealed		conducted following resident falls to insure new interventions are reflected. Negative results will be reviewed at Qu -DNS/designee will be responsible. Corrective action will be completed by	API

If continuation sheet Page 8 of 50

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245270	B. WING		07/17/2015	
	PROVIDER OR SUPPLIER	HITEWATER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIC DATE	
F 280 F 309 SS=D	assist to ambulate to independent mobility ambulate with nurse without assistive de- one. The care given the care plan. 07/16/2015 10:34 at and the Director of plan copy given to se plan. Also verified to plan is conflicting, r and care plan has in 483.25 PROVIDE CO HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psychol	dicated R45 was a one person to/from the bathroom, ty in room, and R45 should ing two to three times daily evice and a stand by assist of guide was found not to match m. Registered Nurse (RN)-A Nursing (DON) verified care surveyor is most current care he information on the care esident is not independent, ncorrect information. CARE/SERVICES FOR	F 28		8/26/15	
	by: Based on observat review, the facility fi implemented physic for 1 of 1 resident ( physician's order fo Findings include: R33's diagnoses we	NT is not met as evidenced ion, interview and document ailed to ensure the facility cian orders to prevent edema R33) reviewed who had a r antiembolism stockings. ere identified on the quarterly MDS) assessment to include:		F309 -Physician orders for R33 have been reviewed and implemented as ordered -All residents have the potential to be affected if physician orders are not implemented when ordered. -Nursing staff have been educated on following physician orders and process requesting needed supplies. Facility h ordered an adequate supply of	for	

Facility ID: 00942

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	OF DEFICIENCIES	& MEDICAID SERVICES		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	COMPLETED	
		245270	B. WING _			17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	<ul> <li>F 309 Continued From page 9 congestive heart failure (CHF), hypertension (HTN), diabetes mellitus (DM), cerebrovascular accident (CVA), dementia and atrial fibrillation.</li> <li>Review of R33's Physician's Orders And Signature Form revealed an order dated 7/7/15, which directed "Needs Tubigrips or Compression stockings on AM (morning), off PM (evenings) secondary to edema."</li> <li>On 7/16/15, at 9:09 a.m. R33 was observed being wheeled down the hallway towards the desk by a family member (F1) who was at the facility visiting. R33 was observed wearing sweat pants, and he had on ankle socks and house slippers. At the time of the observation both of R33's ankles were uncovered and were noted to be swollen as F1 took him into his room. At 9:13 a.m. F1 was observed in R33's room helping to put the TV (television) on. Although R33 had</li> </ul>	F 30	anti-embolism stockings f use when ordered. - Audits will be completed an adequate supply of ant stockings are available an requiring anti-embolism st wearing them. Negative re reviewed at QAPI. -DNS/designee will be res -Corrective action will be o 8/26/15.	weekly to insure i-embolism id residents cockings are esults will be ponsible.			
	wearing observed t On 7/16/15, at 12:2 the dining room (DI the table eating lun either Tubigrips or that time but was s R33's ankles remai On 7/17/15, at 8:19 R33 was observed the DR table. R33 stockings nor Tubig ankle socks. Both were observed to b On 7/17/15, at 8:20	a.m. and again at 9:03 a.m., seated on his wheelchair at was not wearing compression grips but was wearing black ankles were uncovered and					

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		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING _			07/	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WI	HITEWATER			25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	dated 7/7/15, to app stockings for R33 w would check after s breakfast medication On 7/17/15, at 8:57 (DON) stated she h therapy department ordered the stockin had a staff person of stockings may have asked if the stockin the DON stated, "if would send them do to clean them in the On 7/17/15, at 9:03 stated, "For months stockings. We can swollen and we elev never seen them." I swollen and stated socks. On 7/17/15, at 10:1 ordered the compre- the stockings would own system and no indicated at the faci person designated executive director of go in and accept the asked whether the staff had called in s On 7/17/15, at 10:2 surveyor and stated	opy Tubigrips or compression vas current. RN-D stated she she was done with the on pass. T a.m. the director of nursing had talked to staff in the t and learned that they had igs. She further stated she checking whether the e been sent to laundry. When higs were sent to laundry daily they were soiled the staff own because they aren't able e sink." a.m. nursing assistant (NA)-F is he has not had TED (elastic) only tell the nurse the legs are vate them. I help him and have NA-F verified R33's legs were R33 routinely wore ankle 3 a.m. when asked who ession stockings RN-D stated d be ordered from the facility's of from the pharmacy. RN-D ility level there would be a to make the orders the or DON would be the ones to e order placement. When staff responsible for ordering available, the ED stated the	F 30	)9			

Facility ID: 00942

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245270	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(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 APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309 F 323 SS=J	stockings have bee acknowledged the o stockings had not b verified R33 had sw On 7/17/15, at 11:2 would expect the or stockings for this ca followed up to make applied. I expected implemented." The compression stocki ordered. R33's care plan dat impaired cardiovase and atrial fibrillation to observe for, and edema, shortness of resident's lower ext The facility's policy (Elastic Stockings), purpose of the stoc prevent embolus fo circulation from low support to the lower 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	n ordered." She order for the compression eeen completed until now and vollen ankles. 9 a.m. the DON stated, "I rder to be done and the ase to have been ordered and e sure they were delivered and the order to have been DON acknowledged the ngs had not previously been ed 3/20/14, indicated R33 had cular status related to HTN . The care plan directed staff report, signs of chest pain, of breath and to elevate the remities as indicated. for Anti-embolism Stockings dated 2006, indicated the kings was to reduce edema, rmation, to aid return er extremities. FACCIDENT	F 309			8/26/15

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			()(0)			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245270	B. WING _		07/17/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 323	Continued From pa	ge 12	F 3	23		
	by: Based on observat review, the facility fa interventions includ assistance and/or a in order to prevent of foods for 2 of 2 resi been identified as a implement these int immediate jeopardy The immediate jeop it was first observed the necessary supe and food consistent meal service observ administrator, a cor administrator, a cor administrator, a cor administrator, and a from the corporate immediate jeopardy 2015 but noncompl scope and severity and severity level, w with potential for me not immediate jeop Findings include: R12 and R51's medical reco Speech language p progress notes indir risk for choking and R51's medical reco aspiration pneumor the time of admission having a diagnosis swallowing). Althou	porate executive a clinical services specialist office were notified of the v at 5:32 p.m. on 7/14/15. The v was removed on July 16, iance remained at the lower level of D - isolated, scope which indicated no actual harm ore than minimal harm that is		<ul> <li>F323</li> <li>-R12 and R51 were evaluated by therapy for proper diet and fluid consistency. Recommendation supervision while eating or drinkin been implemented, care planned, being followed.</li> <li>-Residents at risk for aspiration has potential to be affected if proper supervision is not provided while or drinking.</li> <li>-Nursing staff have been educate following therapy recommendation supervision during meals. Licens have been educated on signs/sym of aspiration and steps to take if a suspected.</li> <li>-Weekly audits will be conducted therapy recommendations for supare being implemented as written Negative results will be reviewed.</li> <li>-Twice weekly audits for compliant varied meals or snacks with varie involved for one month. Will revie QAPI to determine need to contin -DNS/designee will be responsibleCorrective action will be complete 8/26/15.</li> </ul>	s for g have and are ave the eating or d on ns for ed staff nptoms spiration to review ervision at QAPI. ce over d staff w at ue. e.	

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	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MUI 7	TIPLE CONSTRUCTION		. 0938-039 E SURVEY
-	CORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	IPLETED
		245270	B. WING		07/17/2015	
ME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
OLDEN I	LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 323	Continued From pa	age 13	F 3	23		
	•	erventions were implemented				
(	consistently.					
		during the evening meal on n. to sit at the dining room				
		y drinking hot chocolate with no				
		12 was observed to begin to				
		after a drink of the hot				
		hot chocolate was observed to				
		h. Nursing assistant (NA)-C, sing out wipes to other				
		ing room came over to R12,				
1	handed R12 a wipe	e and left the area. NA-C did				
		as okay, or whether he was				
		allowing the hot chocolate. 3/15, R12 again began to				
		. This time the cough was				
		pinkish/red colored liquid				
9	spewed from his m	outh. There were no staff				
		nediate area, R12's face				
		ontinued to cough. Registered to the table about 2 minutes				
		had started and at 7:00 p.m.,				
		2 (in his wheelchair) from the				
(	dining room while h	ne continued to cough. R12				
		e lobby. RN-B then re-entered				
		d asked about what R12 had				
		stated the red apple sauce was considered pureed fruit,				
		ance in the glass was a "thicker				
	than pudding thick'					
		was observed seated alone in				
		I table against the wall. He				
5	staff who might be	in the area. RN-B had his food				
1	tray brought out an	d placed in front of him. Again				
       	had stopped cough returned to normal towards the wall m staff who might be tray brought out an R12 was left unsup	ning and his face color had . R12 was noted to be facing aking him less easily visible by in the area. RN-B had his food				

Facility ID: 00942

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TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
ND I LAN C		DENTITION TO NOW DET.	A. BUILDI	ING			
		245270	B. WING			07/17/2015	
NAME OF I	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVINGCENTER - V	VHITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETIC DATE	
F 323	Continued From p	age 14	F 3	323			
		PN)-A, was observed standing					
		rt 15-20 feet away with her					
		11 p.m. R12 remained in the A clinical psychologist (CP)-A					
		pproach R12 to remove his					
	dinner tray at 7:13	p.m. At that time, the surveyor					
		her she'd had any formal					
		esidents with eating. CP-A thad any training for assisting					
		ut was removing the resident's					
	tray because the s	surveyors were watching the					
	resident.						
		t meal observation on 7/14/15 was observed to sit at the					
		with his breakfast tray in front of					
		o staff sitting with the resident					
		supervising the resident. R12 m of wheat, held it in his mouth					
		3 seconds and began to cough.					
		ved to drip out of his mouth and					
		At 9:05 a.m. NA-C was					
		over to R12 and whether he NA-C was heard to instruct					
		swallow." NA-C stayed at R12's					
	table until 9:07 a.n	n. when she left R12's table and					
		er table to feed a different					
		.m. As R12 continued to eat vas observed to take several					
		hold it in his mouth for long					
	periods of time be	fore swallowing. R12 did not					
		procedure while eating nor did					
	staff monitor R12	while he was allowing or cue him to use the					
		re. NA-C did not return to					
	R12's table until 9	:13 a.m.					
		w on 7/14/15, at 9:24 a.m.					
		an (RD)-A explained the ncy for pureed food is					
		erified the consistency of food					

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		245270	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 323	and fluids for R12 s consistency. RD-A added as needed to consistency was pr ordered. RD-A also aspiration precautio supervision in the c During observation p.m., R12 sat at the mouth. No staff we direct view of R12 of tray included puree thick consistency. During an interview dietary assistant (D determined the cor sticking a spoon in stands straight up, pudding thick. DA-/ served R12's carro consistency. Following the facilit was observed at 6: supper meal. R12 and was moaning le between R12 and F take a heaping spo Although RN-B inst bites, she did not in chin and swallow. I hold the cranberry j approximately 7 se took another bite th bite, and was again mouth for several se bites and each time seconds in his mou	should be pudding thick stated thickener should be o R12's food and fluid epared as the physician had stated, "people who have ons, including R12, need direct	F 32			

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CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION (X1) PROVIDEN/SUPPLIEN/CLIA IDENTIFICATION NUMBER: 245270			A. BUILDING			COMPLETED	
		B. WING _		07/17/2015			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 323	Continued From page 16 encourage R12 to use the chin-tuck technique. At 6:32 p.m. RN-B picked up R12's spoon and attempted to feed him. At 6:33 p.m. During the observation RN-B was also observed to assist R51 with eating. While RN-B was assisting R51, R12 resumed feeding himself. When RN-B returned to assist R12, she was observed to put food on the spoon and place bites in R12's mouth while there was still food in R12's mouth. R12 had food running out of his mouth, and was observed to hold food in his mouth at the same time. No instruction was provided for R12 to use chin-tuck then to swallow. At 6:39 p.m. R12 was observed to take a bite and to hold it in his mouth. R12 cried out "Ahh" and then began to cough. R12 then closed his mouth for a few seconds and when he opened his mouth again, a large amount of tan colored liquid drained out of his mouth onto his clothing protector. At 7:15 p.m. R12 was removed from the dining area and set in the lobby area. During an interview with RN-B at 7:21 p.m. on 7/14/15, RN-B told the surveyor R12 had experienced a brief choking episode in the dining room. RN-B stated she and two nursing assistants had intervened. RN-B stated R12 had several bites of food in his mouth at the time. When the surveyor inquired, "How did he get that		F 32	23			
	much food in his m eating right along a swallowing but he o pretty close." On 7/14/15, at 8:01 and administrator w noted during the su During an observat 7/15/15, at 8:20 a.m dining room table w	outh?" RN-B stated, "He was nd I thought he was didn't swallow. I was watching p.m. the director of nursing vere informed of the concerns upper meal with R12. ion of the breakfast meal on n. R12 had been sitting at the <i>v</i> ith no staff member present at R12 was served the correct					

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         245270		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			0MB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/17/2015			
							NAME OF PROVIDER OR SUPPLIER	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETIC DATE		
F 323	spoon and attempt cranberry juice from the table and only of take smaller bites. the table without as bites of food, and w present with R12 to At 8:26 a.m. the su of RD-A and RN-A supervise the resid thickened drinks he a.m. RN-A was obs R51 and R12 and s because the drinks the table" At 8:3 in front of him, and bite, he experience time, RN-A gave ve chin tuck procedure observed to assist down next to R51, moved to the other another resident, th table to wash her h table, RN-A also go side of the table to leaving R12 withou returned to the table side with her back couple of bites of fo were observed to co point the surveyor i of the concern with while independently with R12 at 8:58 a. meal. R12 was admitted	age 17 ages, when R12 grabbed his ed to remove a heaping bite of n the glass, RN-B walked by gave a verbal cue for R12 to RN-B then walked away from asisting R12 to take smaller vithout ensuring staff were o supervise as he ate his meal. rveyor brought to the attention that there was no one to ent as he attempted to eat the e had been served. At 8:27 served to sit down between stated, "I am sitting here were prematurely delivered to 36 a.m. R12's meal was placed as he independently took a ed a coughing incident. At that erbal cues to R12 to follow the e. At 8:39 a.m. RN-A was R51. At 8:41 a.m. NA-G sat however at 8:45 a.m. NA-G side of the table to assist nen walked away from the ands. When NA-G left the of up and moved to the other assist the other resident t any assistance. NA-G e, however sat on the other to R12. After R12 had taken a bod, copious amounts of saliva train from his mouth. At that intervened and informed RD-A R12 not being supervised y eating. RD-A got RN-B to sit m. until R12 had completed his to the facility on 9/3/14 cility admission record with	F 3	323				

Facility ID: 00942

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		AND HUMAN SERVICES				FORM	: 08/19/2015 APPROVED : 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245270	B. WING			07/	17/2015			
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>				
GOLDEN	GOLDEN LIVINGCENTER - WHITEWATER			525 BLUFF AVENUE ST CHARLES, MN 55972						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 323	diagnoses that inclu dementia with beha (difficulty swallowin hearing loss, and a R12's quarterly Min 5/26/15, indicated F impairment with a E Status score of 10 The MDS indicated responded adequat communication. In R12 experienced comeals or when swa required staff super eating and meal se R12's quarterly nutto 6/12/15, indicated F and required thicke included, "Puree no white rice, no moongoing difficulties The record also ind speech therapy ser 5/6/15, for medical vascular accident a Therapy notes indic 4/6/15- "R12 choke session, had delaye In addition, the note given to staff on ho seconds to elicit sw meats if needed, ar 4/7/15- "education of food from the reside spoon for liquids." 4/8/15-"required ma verbal cues to use of related to coughing	uded but were not limited to: wioral disturbance, dysphagia g), esophageal reflux, central nxiety disorder. imum Data Set (MDS) dated R12 had moderate cognitive Brief Interview for Mental which indicates confusion. R12 had unclear speech, but tely to simple direct addition, the MDS indicated oughing and/or choking during llowing medication, and vision and assistance with t up. rition assessment dated he had a swallowing disorder ned liquids. The assessment diet with pudding thick liquids, ilk with mealsr/t [related to] with swallowing" licated R12 had received vices from 2/18 through diagnoses of: cerebral nd treatment for dysphasia.	F	323						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         245270         NAME OF PROVIDER OR SUPPLIER			A. BUILC	PRINTED: 08/19/2 FORM APPROV OMB NO. 0938-0 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE					
GOLDEN LIVINGCENTER - WHITEWATER			525 BLUFF AVENUE ST CHARLES, MN 55972						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 323	addition the treatment does not appear to self-feeding, at this care] with increase risk of aspiration." 4/9/15- The note ind in his mouth and reavisual cues to swall the resident had 3 of became anxious. The speech therapic communicated on a Recommendations with honey thick liquid staff sitting by him a tuck chin on swallow bite, use a spoon for (help with bite size a On 4/13/15 speech order from honey the liquids. 4/15/15 - "educati compensatory strate taking small bites and sips, avoid slurping sitting upright, chin flexion, etc.) to assi R12 had increased himself, and educat need for increased case of aspiration o 4/23/15 - "maximu Coming out right sic side. Verbally walke [technique]." R12's care plan was 7/14/15. The care p difficulty swallowing	ent note read, "Pt [patient] be a good candidate for time continue POC [plan of in staff education to decrease dicated R12 held medications quired maximum verbal and ow. The note also indicated coughing episodes and then st orders dated 4/10/15, were a form entitled Rehab and included: "Pureed diet uids, Patient [R12] must have at meals, cue for patient to w, clear mouth prior to next or drinks, and take small bites as needed)." therapy had changed the nick liquids to pudding thick to nwas given to staff for cuing egies (these would include nd sips, alternate bites and and drinking through straws, tuck also known as head st R12 in swallowing safely, coughing when he fed tion was given to staff 'on supervision during meals' in	F	323					

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	F OF DEFICIENCIES	& MEDICAID SERVICES			MB NO	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245270	B. WING _		07/	17/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDE	N LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETI DATE
F 323	staff to use the phy with pudding thick I milk with meals. The staff to "encourage language pathologic coughing during me allow rsdt [resident] staff assist as need been revised to increcommendations in R51 was observed the breakfast meal eating his meal indition to have honey thick and oatmeal. Ther table to supervise F take a bite of oatme immediately R51 be observed to take an again coughed sev dining room were a did not check on R coughing episodes assistant, (NA)-C, f did not intervene fo tablemate's with ear During an evening at 6:13 p.m. R51 w dining room table d honey thickened ho (RN)-B sat between R51's food, which w appropriate consist him. From 6:23 p.m independently without	sician ordered diet of pureed iquids, no white rice, and no he care plan further instructed to follow SLP [speech st] recommendations, monitor eals, eating assistance of 1, ] to attempt to feed self with ded." The care plan had not lude the SLP's specific identified on 4/10/15. at 9:13 a.m. 7/14/15, during to be sitting at the dining table ependently. R51 was observed sened fluids, scrambled eggs e was not a staff person at the R51. R51 was observed to eal and to chew. Almost egan to cough. R51 was nother bite of oatmeal and eral times. Facility staff in the assisting other residents and 51 when he had these . At 9:19 a.m. a nursing first came to R51's table but or R51, but assisted one of his iting. meal observation on 7/14/15, as observed seated at the linking what appeared to be of chocolate. Registered nurse in R51 and R12. At 6:23 p.m. was observed to be the tency, was placed in front of n. to 6:28 p.m. R51 ate out any verbal cues from oserved to take large bites, and		23		

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		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245270	B. WING	i		07/	17/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - WI	HITEWATER			525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	was in his mouth. A face R51 and instru- bites. At that time F of R51's plate and r into R51's plate and r into R51's plate. At 7:01 and his face turned needed to stop cou- bite. R51 waited un then took a drink, a times but did not tu another drink and a however staff did not the chin tuck proces At 7:11 p.m. on 7/14 (DON) brought R51 wheelchair and place television and gave twice, as the DON w was observed to sta approximately 30 se clear liquid drained used the tissue to v ceased after R51 w During an interview 7/14/15, following th "towards the end sputtering, so I patt coughed and got it alright, you can hea she could tell it had can tell that he clea hear it gurgling any During an observat 7/15/15, at 8:20 a.m	At 6:28 p.m. RN-B turned to locted R51 to take smaller R51 moved the food to center removed food that had fallen a fork, and placed it back onto p.m. R51 started to cough red. RN-B instructed R51 he ghing before taking another til the coughing had stopped nd again coughed several rn red. At 7:08 p.m. R51 took again began coughing, ot give any verbal cues to use dure prior to swallowing. 4/15, the director of nursing out of the dining room in his ced him in front of the him a tissue. R51 coughed walked away. At 7:13 p.m. R51 art coughing again, and after econds his face turned red, from his mouth, and R51 vipe his face. The coughing riped his face. with RN-B at 7:21 p.m. on ne evening meal, RN-B stated, of the meal he [R51] started ed him on the back and he out of his throat, so he's ar it cleared." When asked how cleared, RN-B stated, "You ared it because you couldn't	F	323			

Facility ID: 00942

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AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       C         245270       B. WING       0         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       525 BLUFF AVENUE         GOLDEN LIVINGCENTER - WHITEWATER       STREET ADDRESS, CITY, STATE, ZIP CODE       525 BLUFF AVENUE         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         F 323       Continued From page 22 present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.       F 323         At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51 meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoorful of French toast. When R51 had put the bite in his mouth, RN-A who was also stifting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites. At 8:45 a.m. NA-G moveed away from R51	ND PLAN OF			$(\Lambda Z)$ IVIL II	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GOLDEN LIVINGCENTER - WHITEWATER       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION         F 323       Continued From page 22 present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.       F 323         At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites. At 8:45 a.m. NA-G moved away from R51		CONTRECTION				· · ·	MPLETED
SUMMARY STATEMENT OF DEFICIENCIES TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PRETIX TAG     PROVIDERS PLAN OF CORRECTION PRETIX TAG       F 323     Continued From page 22 present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.     F 323       At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites. At 8:45 a.m. NA-G moved away from R51			245270	B. WING		07	//17/2015
GOLDEN LIVINGCENTER - WHITEWATER       ST CHARLES, MN 55972         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 323       Continued From page 22 present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.       F 323         At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites. At 8:45 a.m. NA-G moved away from R51		ROVIDER OR SUPPLIER				=	
PREFX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 323       Continued From page 22 present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.       F 323         At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites. At 8:45 a.m. NA-G moved away from R51	GOLDEN	LIVINGCENTER - W	HITEWATER				
present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51. At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites. At 8:45 a.m. NA-G moved away from R51	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETIC DATE
to assist his tablemate. R51 continued to eat independently without verbal cues. NA-G then walked away from the table to wash her hands. At the same time, RN-A got up and went to the other side of the table to assist R51's tablemate. When NA-G returned to the table, she sat at the opposite side from R51. At 8:58 a.m. RN-A continued to assist the tablemate (R12) with her back to R51. From 8:45 a.m. until 8:58 a.m. R51 was observed to eat independently, and was observed to take large amounts of food with each bite taken. At 8:58 R51 started coughing and his face turned red, RN-A suggested at that time that it would be good to "get a therapy referral for adequate chair positioning while eating."		present at the table beverages of the co began to drink inde supervision. RN-B table and provide v offer any cues or as At 8:26 a.m. on 7/1 about R51 having r staff availability to a was not sure how t a.m. RN-A sat betw "I am sitting here b prematurely deliver R51's meal was pla a.m. NA-G sat next himself to a heapin When R51 had put who was also sittin and said, "Tell him NA-G looked at R5 bites. At 8:45 a.m. to assist his tablem independently with walked away from At the same time, F other side of the tal When NA-G return opposite side from continued to assist back to R51. From was observed to ea observed to take la bite taken. At 8:58 face turned red, RN it would be good to adequate chair pos	<ul> <li>a. R51 was served the orrect consistency which he ependently without staff was observed to walk by the erbal cues to R12, but did not ssistance to R51.</li> <li>5/15, RD-A was questioned eccived his beverages prior to assist him. RD-A stated she hat had happened. At 8:27 ween R51 and R12 and stated, ecause the drinks were red to the table." At 8:36 a.m. aced in front of him and at 8:39 to the R51 who had helped g spoonful of French toast. The bite in his mouth, RN-A g at the table looked at NA-G [R51] to take smaller bites." 1 and told him to take smaller NA-G moved away from R51 hate. R51 continued to eat but verbal cues. NA-G then the table to wash her hands. RN-A got up and went to the ble to assist R51's tablemate. ed to the table, she sat at the R51. At 8:58 a.m. RN-A the tablemate (R12) with her 8:45 a.m. until 8:58 a.m. R51 at independently, and was trge amounts of food with each R51 started coughing and his V-A suggested at that time that "get a therapy referral for sitioning while eating."</li> </ul>	F 3	23		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245270	B. WING		<b>07</b> / <sup>.</sup>	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	N LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa face sheet indicated the facility on 11/5/1 the facility admission included: dysphagia problems with swal (chewing), Parkinson A Physician Visit no R51 had been seer and low-grade temp exam revealed "cra and occasional exp documentation indi- diagnosed with asp been prescribed Au milligrams (mg) twin nebulizer treatment A nursing progress able to fed [feed] set table for supervision thick liquids." R51's annual Minim 5/26/15, indicated F self-understood how communicating sort but was able if pror- usually be understor	age 23 d R51 had been admitted to 13. In addition, according to on record, R51's diagnoses a, aspiration pneumonia, llowing and mastication on's, dementia, and anxiety. ote dated 5/12/15, indicated n that day because of a cough perature. The physician's ackles in right mid lung field biratory wheeze." The physician cated R51 had been biration pneumonia, and had ugmentin (an antibiotic) 875 ce a day for 7 days, and a t for four days and as needed. note dated 5/23/15 read, "is elf after set up, is at the feeder n. Eats slowly, is on nectar	F 323	DEFICIENCY)		
	messages but com R51 was identified interview for menta which indicated mile MDS further indicat physical assistance eating.	miss some parts or intent of prehended most conversation. by the MDS to have a brief al status (BIMS) score of 11 d cognitive impairment. The ted R51 required limited from one staff member for				

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245270	B. WING			07/	17/2015
	PROVIDER OR SUPPLIER	HITEWATER		525	REET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 323	assessment indicat physician prescribe puree meets and ve liquids, no added sa nutritional assessm "Resident has ha [due to] an occurrent pneumonia in May meal times now." The record indicate therapy from 3/3 th signs and symptom according to the Sp Updated Plan of Ca Speech therapy not written recommend from nectar thick lice On 3/24/15 speech additional recommend to mechanical soft meats, and honey to recommendation in at meals, make sur scrambled." Speech therapy pro- indicated R51 utilized with 90% accuracy R51's care plan pro- 7/14/15, identified a difficulties related to pneumonia. The ca- staff to provide a di	of swallowing disorder. The ted the resident had a ad diet of mechanical soft with egetables with honey thick alt, no magic cups. The tent summary note included, d some changes to diet d/t nce [sic] of aspiration [2015]Resident is assisted at ed R51 had received speech rough 4/17/15, to decrease as of penetration/aspiration, beech Therapy Progress and are form dated 3/3/15. tes dated 3/19/15, included a lation to change R51's diet quids to honey thick liquids. therapy had made an endation to change R51's diet with pureed vegetables and		323			

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		AND HUMAN SERVICES				FORM	: 08/19/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING	à		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - W	HITEWATER			525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETION DATE
F 323	provide assistance allow. In addition the to sit at the 'assiste had not been revise speech therapy rec 3/24/15. During an interview at 2:27 p.m. on 7/14 aware R51 was not eggs, but should ha consistency and did During an interview p.m. she stated, "U two [identified R12 often that [R51]I eating, I don't need During an interview p.m. she stated, "F direct supervision- chin and swallow, F what is happening staff members to fe basically go back a aides in the dining find management will h during the evening. but they never are if whole meal service R51 cough at every NA-C explained R5 cueing then said, " reference to cough During an interview NA-H was asked all	at meals as the resident would be care plan indicated R51 was ad dining table'. The care plan ed to include the specific commendations identified on with dietary assistant (DA)-A 4/15, DA-A stated she was not t supposed to have scrambled ave received eggs of a pureed d not. with NA-K on 7/14/15 at 2:15 sually every day there are just & R51] that cough, [R12] more R51 does good on his own to sit by him when he eats." with NA-C on 7/14/15 at 2:15 R12 needs and should get he needs to be told to tuck his he holds food in his mouth, right now is there isn't enough eed 10 people so we have to and forth. There are only two room during meals, sometimes elp during the day but not A nurse might help pass trays in the dining room during the s." NA-C stated both R12 and y meal at least 3 to 4 times. 51 needed supervision and 'He's not as bad as [R12] " in	F	32:	3		

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PRINTED: 08/19/2015 FORM APPROVED

		AND HUMAN SERVICES			FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245270	B. WING		<b>07</b> / <sup>.</sup>	17/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - WI	HITEWATER		25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	NA-H stated the co because they both During an interview stated she normally verified there are us dining room. NA-I s help if they were do stated most of the t During an interview NA-J stated she wo that there are usual room to assist all of assistance with eat assistants have to r the two tables. NA-keep shoveling food bites and that is us NA-J then explaine R12 and R51 were A facility policy Eatin did not identify guid required changes to of residents who we	king episodes while eating. ughing usually occurred (R12 and R51) eat too fast. y on 7/14/15 at 7:15 p.m., NA-I y worked the evening shift and sually only two NA's in the stated a nurse might be able to one passing medications, but time it is just the two aides. y on 7/14/15, at 7:21 p.m., orked on the evening shift and lly just two staff in the dining f the residents that need ing. NA-J stated the nursing move back and forth between J also stated R12 "likes to d in his mouth" and takes big ually when food comes up. d prevention measures for to give verbal cues. ng Support was reviewed and delines to assist residents who o textured diets or supervision ere at risk for choking and/or	F 323	DEFICIENCY)		
	precautions was red at 9:56 a.m. RD-A a not have a policy. The immediate jeon was removed on 7/ the facility had com and R51 to rule det had revised the res	pertaining to aspiration quested, however on 7/17/15, and DON stated the facility did pardy that began on 7/13/15, (16/15, when it was determined apleted assessments for R12 termine their aspiration risks, idents' care plans to include rapy recommendations, it was				
	current speech ther	rapy recommendations, it was een re-educated to understand				

Facility ID: 00942

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		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING			07/	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	I LIVINGCENTER - W	HITEWATER			25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	during meals, and h resident specific int aspiration, and obs appropriate implem However, noncomp scope and severity and severity level, w with potential for me the facility's popular swallowing difficulty 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	upervision of the residents nad been re-educated to erventions for prevention of ervation of a meal reflected entation of interventions. Jiance remained at the lower level of D - isolated, scope which indicated no actual harm ore than minimal harm due to tion including residents with <i>x</i> . EGIMEN IS FREE FROM RUGS g regimen must be free from . 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 3				8/26/15

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			FORM OMB NO.	08/19/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245270	B. WING _		07/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATI	E, ZIP CODE	
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From pa	ige 28	F 32	29		
	by: Based on observat review, the facility f document non-pha to using as needed behavioral outburst (R8, R41 and R22) medications. Findings include: R8's most recent pl and dated 7/7/15, r the following psych (anxiety medication pulse areas topical anxiety, and to app R8's Medication Ad On 7/3/15, Ativan 0 topically for anxiety behavior. On 5/14/15; 5/23/28 behavior) Ativan 0.5 topically for anxiety documentation on t administered topica On 4/15/15, (no bel day), Ativan 0.5 mg anxiety. In addition, there w	NT is not met as evidenced tion, interview and document ailed to implement and rmalogical interventions prior (PRN) medications for s or pain, for 3 of 5 residents reviewed for unnecessary hysician order sheets signed evealed that R8 had orders for oactive medications: Ativan b) 0.5 milligrams (mg), apply to by every 4 hours as needed for ly Ativan gel to pulse areas. ministration Record revealed: 0.5 mg was administered 5 (no documentation of 5 mg was administered a) and on 5/29/15, no behavior that day, Ativan 0.5 mg was ally for anxiety. havior documentation on that g was administered topically for havior documentation on that g was administered topically for havior documentation on that g was administered topically for		F329 -Non-pharmacological being implemented an to administration of pr R8, R41, and R22. -Residents receiving p have the potential to b non-pharmacological identified, attempted, a prior to administration -Licensed nursing stat educated on the requi document non-pharma interventions and effer administration of prn r -Two to three weekly a will be conducted of p medications to ensure of non-pharmacologic the results of these int administration of prn r Negative results will b and action planned as be reviewed at QAPI t contination. -DNS/Designee will be -Corrective action will 8/26/15.	nd documented prior n medications for orn medications be affected if interventions are not and documented If have been rement to offer and acologic ctiveness prior to nedications. audits for 30 days rn administration of the documentation al interventions prior to nedications. e reviewed at QAPI a needed. Results to to determine further e responsible.	

If continuation sheet Page 29 of 50

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED
	245270	B. WING		07	/17/2015
OVIDER OR SUPPLIER					
LIVINGCENTER - W	HITEWATER		ST CHARLES, MN 55972		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO DATE
non-pharmacologic attempted by staff Ativan to R8 for 5 of R8's nurses' notes B/3/14-7/12/15 and ndicate that non-p were attempted pri- ativan. A review of the nur R8 for the past yea no direction provide attempt non-pharm behaviors. R41's most recent and dated 7-9-17 R41 had orders for medications: Ativat medication), Apply needed for anxious n 1 mg/ml individu topically to pulse p Tegaderm if the res- medication off. R41's Medication A revealed: a. On 4/3/15 - Ativat was administered for cord (MAR) that nterventions were	cal interventions were prior to administering the of 6 doses administered. were reviewed from I revealed no documentation to harmacological interventions or to the administration of R8's sing assistant care sheets for ar also revealed there had been ed for the nursing assistants to halogical interventions for R8's physician order sheets signed (error in date) revealed that the following psychoactive in Solution (antianxiety to pulse regions topically as sness and agitation, Supplied al syringe dose. Apply 0.5 ml oints as needed. Cover with a sident is rubbing the Administration Records an Solution 0.5 milliliters (mI) for anxiety and 4/15; Ativan Solution 0.5 ml for anxiety. There was no the medication administration non-pharmacological attempted by staff prior to		29		
	DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LIVINGCENTER - W SUMMARY ST, (EACH DEFICIENC REGULATORY OR I Continued From pa non-pharmacologic attempted by staff Ativan to R8 for 5 of R8's nurses' notes B/3/14-7/12/15 and indicate that non-p were attempted pri ativan. A review of the nur R8 for the past yea no direction provid attempt non-pharm behaviors. R41's most recent and dated 7-9-17 R41 had orders for medication), Apply needed for anxious in 1 mg/ml individu topically to pulse p Tegaderm if the res medication off. R41's Medication A revealed: a. On 4/3/15 - Ativa was administered f documentation on record (MAR) that interventions were administering the A	CORRECTION       IDENTIFICATION NUMBER:         245270         ROVIDER OR SUPPLIER         LIVINGCENTER - WHITEWATER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 29 non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.         R8's nurses' notes were reviewed from 8/3/14-7/12/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R8's ativan.         A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to attempt non-pharmalogical interventions for R8's behaviors.         R41's most recent physician order sheets signed and dated 7-9-17 (error in date) revealed that R41 had orders for the following psychoactive medications: Ativan Solution (antianxiety medication), Apply to pulse regions topically as needed for anxiousness and agitation, Supplied in 1 mg/ml individual syringe dose. Apply 0.5 ml topically to pulse points as needed. Cover with a Tegaderm if the resident is rubbing the medication off.	DF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILDI 245270         ROVIDER OR SUPPLIER       245270       B. WING         LIVINGCENTER - WHITEWATER       ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIC TAG         Continued From page 29 non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.       F 3         R8's nurses' notes were reviewed from B/3/14-7/12/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R8's ativan.       F 3         A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to attempt non-pharmalogical interventions for R8's behaviors.       R8's nost recent physician order sheets signed and dated 7-9-17 (error in date) revealed that R41 had orders for the following psychoactive medications: Ativan Solution (antianxiety medication), Apply to pulse regions topically as needed for anxiousness and agitation, Supplied in 1 mg/ml individual syringe dose. Apply 0.5 ml topically to pulse points as needed. Cover with a Tegaderm if the resident is rubbing the medication off.         R41's Medication Administration Records revealed: a. On 4/3/15 - Ativan Solution 0.5 milliliters (ml) was administered for anxiety. There was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan Solution for R41.	SF DEFICIENCIES CORRECTION       (X1) PROVIDER SUPPLIER(LIA IDENTIFICATION NUMBER: 245270       (X2) MULTIPLE CONSTRUCTION A. BUILDING         OWIDER OR SUPPLIER       245270       B WING         LIVINGCENTER - WHITEWATER       STREET ADDRESS, CITY, STATE, ZIP CODE 526 BLUFF AVENUE SUMMARY STATEMENT OF DEFICIENCIES ICACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIDENT SPLAN OF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 29 non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.       F 329         R8's nurses' notes were reviewed from 8/3(14-7/12/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R8's tativan.       F 329         A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to tattempt non-pharmalogical interventions for R8's behaviors.       F Aris most recent physician order sheets signed and dated 7-9-17 (error in date) revealed that R41's Medication Administration Records revealed for anxiousness and agitation, Supplied n 1 mg/m1 individual syringe dose. Apply 0.5 ml was administered for anxiety and 0. On 5/15/15, 5/12/15, Ativan Solution 0.5 ml was administered for anxiety. There was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan Solu	pFDERIGENCIES CORRECTION       (X1) PROVIDERSUPPLIERQUA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DA COUNDER OR SUPPLIER         LIVINGCENTER - WHITEWATER       STREET ADDRESS, CITY, STATE, ZIP CODE 525 BUUFF AVENUE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY ON IS OLDENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERED TO CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERED ENDING ACH CONTROL ACTION SHOULD BE CROSS-REPERED ENDING (CONTINUED AND ACTION SHOULD BE CROSS-REPERED ENDING (CONTINUED ACTION SHOULD ACTION (CONTINUED ACTION SHOULD ACTION (CON

If continuation sheet Page 30 of 50

TATEMENT	OF DEFICIENCIES	A MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		OMPLETED
		245270	B. WING			7/17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 5597	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE
F 329	Continued From pa	age 30	F 3	329		
		harmacological interventions or to the administration of e medication.				
	non-pharmacologic attempted prior to a medications. The I should be docume behavior charting. no documentation interventions on 4/ (dates when R41 r R22 was admitted according to the fa diagnoses that incl rheumatoid arthritis regions, malignant perforation of intes weakness, patholo	p.m. the DON stated cal interventions should be administration of the PRN DON stated the interventions nted in the progress notes or The DON confirmed there was of non-pharmacological 3/15, 5/15/15, or 5/24/15 eceived PRN ativan). to the facility on 12/29/14 cility admission record with uded but was not limited to s, abscess of anal and rectal neoplasm intestinal tract, tine, osteoporosis, muscle gical fracture of a vertebrae,				
	6/30/15 indicated r Brief Interview for I 15 and required ex complete activities further indicated th	ic pain. himum Data Set (MDS) dated to cognitive impairment with a Mental Score (BIMS) score of ttensive assist from staff to of daily living. The MDS e resident received scheduled ad utilized as needed pain				
	R22's care plan pro- informed staff of the related to: osteopo The care plan direct mediation as order could serve to dista- routinely scheduled	ovided by the facility on 7/14/15 the need for pain management rosis and rheumatoid arthritis. cted staff to administer pain ed, identify items/activities that ract pain, evaluate the need for d medications rather than PRN Iministration, evaluate the need				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	0938-039 SURVEY PLETED
		245270	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER	210210		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	17/2015
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 329	repositioning, move R22's physician ord 7/15/15 included th pain medication: Ty mouth every six ho restlessness, and I 2 hours as needed and 2:00 a.m. R22's medication a were reviewed from 2015. The June MAR ind PRN Tylenol three used in combinatio records indicated th prior to the PRN Di indicated the Tylen after 6/7/15. The M had been administed June; 53 doses we dosing of Tylenol of was not evident in offered for R22 prio Dilaudid. It was als record non-pharma attempted prior to a any of the doses are July's MAR indicate and PRN Dilaudid was not evident in non-pharmacologic attempted prior to the Dilaudid for any of R22's nursing prog for June and July, finotes simply indicated that was administed	cal pain relief strategies (rest, ement to a quiet environment) ders provided by the facility on the following PRN (as needed) ylenol 650 milligrams (mg) by ours as needed for pain and Dilaudid 2 mg by mouth every for pain between 2:00 p.m. administration records (MAR) in June 1,2015 through July 14, icated R22 was administered times total and that it had been in with the PRN Dilaudid; the Tylenol was administered laudid. However, the MAR ol had not been administered laudid. However, the MAR ol had not been administered laudid at the total of 56 times in re administration of PRN o not evident in the medical acological interventions were administration of Dilaudid for dministered. ed no use of the PRN Tylenol was administered 13 times. It	F 3	29		

Facility ID: 00942

If continuation sheet Page 32 of 50

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3)	NO. 0938-039 DATE SURVEY COMPLETED
				G	
		245270	B. WING		07/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 329 F 428 SS=D	was "effective" or ' notes lacked a pai would include loca description of the p During an interview director of nursing documentation of intervention prior tr pain medication. T was that staff woul evaluation which w non-pharmacologi outcome. The facility's policy Medication Manag 2011, did not reflec non-pharmacologi PRN medications. 483.60(c) DRUG F IRREGULAR, ACT The drug regimen reviewed at least of pharmacist. The pharmacist m the attending phys nursing, and these This REQUIREME by: Based on observa	'ineffective." The progress n assessment/evaluation that tion and characteristics or pain. w on 7/16/15 at 11:18 a.m., the (DON) verified the absence of non-pharmacological o the administration of PRN 'he DON stated her expectation Id fully document a pain would include the use of cal interventions and the v Medication Monitoring and ement, last revised November ct current standards for use of cal interventions prior to use of cal interventions prior to use of	F 32		8/26/15

Facility ID: 00942

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				APPROVE . 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED	
		245270	B. WING _		07/	17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 428	administration of as for behavioral outburned R41 & R22) reviews medications. Findings include: R8's most recent pl and dated 7/7/15, ro- the following psych- (anxiety medication pulse areas topicall anxiety, and to app R8's Medication Ad On 7/3/15, Ativan 0 topically for anxiety behavior. On 5/14/15; 5/23/25 behavior) Ativan 0.5 topically for anxiety documentation on t administered topica On 4/15/15, (no bel day), Ativan 0.5 mg anxiety. On 1/10/15, (no bel day), Ativan 0.5 mg anxiety. In addition, there was medication administ non-pharmacologic attempted by staff p Ativan to R8 for 5 o R8's nurses' notes	al interventions utilized prior to a needed (PRN) medications ursts for 3 of 5 residents (R8, ed for unnecessary hysician order sheets signed evealed that R8 had orders for oactive medications: Ativan b) 0.5 milligrams (mg), apply to y every 4 hours as needed for ly Ativan gel to pulse areas. ministration Record revealed: .5 mg was administered . No documentation of 5 (no documentation of 5 mg was administered , and on 5/29/15, no behavior hat day, Ativan 0.5 mg was	F 42	<ul> <li>for irregularities.</li> <li>Residents receiving medication the potential to be affected if irrin medication regimen are not</li> <li>Consultant pharmacist has revimedications for all residents are making recommendations where irregularities are identified.</li> <li>Consultant pharmacist report or reviewed monthly to insure irreare identified. Negative results reviewed at QAPI.</li> <li>DNS/designee will be respons</li> <li>Corrective action will be comp 8/26/15.</li> </ul>	egularities identified. <i>r</i> iewed id is n will be gularities will be ible.		

If continuation sheet Page 34 of 50

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		IPLE CONSTR			(3) DATE	0938-039	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			COM	PLETED	
		245270	B. WING				07/17/2015		
NAME OF I	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP (	CODE			
GOLDEN	I LIVINGCENTER - W	HITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· · · ·	PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETIO DATE	
F 428		harmacological interventions	F 4:	28					
	were attempted pri- ativan.	or to the administration of R8's							
	R8 for the past yea no direction provide	sing assistant care sheets for a also revealed there had been ad for the nursing assistants to alogical interventions for R8's							
	behaviors. R41's most recent and dated 7-9-17 (6	physician order sheets signed error-was to be 7/9/15) nad orders for the following							
	psychotropic medic (antianxiety medica topically as needed Supplied in 1 mg/m	ations: Ativan Solution ation), Apply to pulse regions I for anxiousness and agitation, I individual syringe dose. Ily to pulse points as needed.							
	Cover with a Tegac the medication off. Review of R41's M Record (MAR) reve	lerm if the resident is rubbing edication Administration							
	was administered f b. On 5/15/15; 5/24	or anxiety and I/15; Ativan Solution 0.5 ml or anxiety. There was no							
		cal interventions were prior to administering the R41.							
	5/24/15 and reveal indicate that non-pl	s were reviewed from 4/3/15 to ed no documentation to harmacological interventions or to the administration of c medication.							
	non-pharmacologic	p.m. the DON stated al interventions should be administration of the PRN							

If continuation sheet Page 35 of 50

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	0	MPLETED
		245270	B. WING _		07	/17/2015
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE		
OLDEN	I LIVINGCENTER - WI	HITEWATER		ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 428	medications. The D should be documer behavior charting. T no documentation of interventions on 4/3 R41. On 7/16/2015 5:58 pharmacist (CP)-A attempted non-phar should be complete for the use of PRN On 7/17/15 at 7:05 spoken to his super non-pharmacologic PRN medications w pharmacy review. The Clinical Pharmac commencing on Au Scope of Services medication regimer Facility Patient at le in writing any irregu occurrences to Fac Medical director, Di where appropriate, physician; 1.3 revie Facility Patient at le in writing any irregu occurrences" R22 was admitted t according to the fac diagnoses that inclu rheumatoid arthritis regions, malignant perforation of intest	ON stated the interventions ited in the progress notes or The DON confirmed there was of non- pharmacological 15, 5/15/15, or 5/24/15 for p.m. the consultant stated documentation of macological interventions d in residents' medical record	F 4	28		

If continuation sheet Page 36 of 50

	OF DEFICIENCIES	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
	ST CONTRECTION	DENTI IOATION NOMBER.	A. BUILDI	NG	001	
		245270	B. WING _		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE		
GOLDEN	I LIVINGCENTER - W	HITEWATER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 36	F 42	28		
	6/30/15 indicated r Brief Interview for 15 and required ex complete activities further indicated th pain medication ar medication. R22's care plan pr informed staff of th related to: osteopo The care plan dire- mediation as order could serve to dist routinely scheduler pain medication ac to provide medicat therapy, implement non-pharmacologic repositioning, mov R22's physician or 7/15/15 included th pain medication: T mouth every six ho restlessness, and 2 hours as needed and 2:00 a.m. R22's medication a were reviewed from 2015. The June MAR ind PRN Tylenol three used in combinatio records indicated th prior to the PRN D indicated the Tyleno	himum Data Set (MDS) dated to cognitive impairment with a Mental Score (BIMS) score of tensive assist from staff to of daily living. The MDS te resident received scheduled and utilized as needed pain ovided by the facility on 7/14/15 the need for pain management trosis and rheumatoid arthritis. Cted staff to administer pain red, identify items/activities that ract pain, evaluate the need for d medications rather than PRN dministration, evaluate the need ions prior to treatment or t the patient's preferred cal pain relief strategies (rest, ement to a quiet environment) ders provided by the facility on the following PRN (as needed) ylenol 650 milligrams (mg) by burs as needed for pain and Dilaudid 2 mg by mouth every for pain between 2:00 p.m. administration records (MAR) n June 1,2015 through July 14, hicated R22 was administered times total and that it had been on with the PRN Dilaudid; he Tylenol was administered ilaudid. However, the MAR ol had not been administered MAR indicated PRN Dilaudid				

Facility ID: 00942

If continuation sheet Page 37 of 50

	RS FOR MEDICARE		()(0)		DMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · /	E SURVEY PLETED
		245270	B. WING		07/17/2015	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	HITEWATER		25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 37	F 428			
	was not evident in t offered for R22 price Dilaudid. It was also record non-pharma attempted prior to a any of the doses ac July's MAR indicate and PRN Dilaudid w was not evident in t non-pharmacologic attempted prior to t Dilaudid for any of R22's nursing prog for June and July, t notes simply indica that was administer using a 0-10 pain s was "effective" or "i notes lacked a pair would include locat description of the p During an interview director of nursing documentation of n intervention prior to pain medication. Th was that staff would evaluation which w non-pharmacologic outcome. The facility's policy Medication Manage 2011, did not reflection	ed no use of the PRN Tylenol was administered 13 times. It the medical record cal interventions were the administration of PRN the doses administered. ress notes were also reviewed the majority of the progress ted the PRN pain medication red, the intensity of the pain cale, if the pain medication ineffective." The progress n assessment/evaluation that tion and characteristics or				
F 441		N CONTROL, PREVENT	F 441			8/26/15

If continuation sheet Page 38 of 50

		AND HUMAN SERVICES				FORM	: 08/19/2015 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245270	B. WING	i		07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - WI	HITEWATER			525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	ige 38	F4	441			
	Infection Control Pr safe, sanitary and c	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.					
	Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to	stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a re prevent the spread isolate the resident. (2) The facility musicommunicable dise from direct contact direct contact will tr (3) The facility musical hands after each di hand washing is incor- professional practice (c) Linens Personnel must hand	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted					
	infection.	as to prevent the spread of					

Facility ID: 00942

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		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245270	B. WING			07/-	17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER			25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	by: Based on interview facility failed to esta program that includ symptoms and type causal organisms a infections. In addition a soiled isolation line overflowing in R22's appropriate clean te changing an indwel R12. The facility's fill control program have residents who resid Findings include: LACK of INFECTIO Facility Line Listing sheet from 1/2015 fill flow sheet identified which was to be col coordinator: Room, admission date, typ cultures, treatment, HAI (Healthcare As (Community Acquir Document review L Infections flow sheet 1/2015, twelve resid experienced possib twelve residents ha (i.e. increased urina elevated temperatu	NT is not met as evidenced y and document review, the ablish an infection control led consistent monitoring of e of infection, tracking of and symptom resolution of on, the facility failed to ensure then cart receptacle was not is room; and failed to ensure echnique was used when ling catheter collection bag for failure to establish an infection d the potential to affect all 45 led in the facility. N CONTROL PROGRAM: of Resident Infections flow to 6/2015 was reviewed. The d the following information llected by the infection control unit, resident name, be of infection, symptoms/date, other actions (if needed), and sociated Infection) or CAI	F 4	141	F441 -Facility infection control program includes monitoring of organisms a resolution of infections. Clean tecl is being used when changing indw catheter collection bag for R12. Li receptacle has been removed from room. -All residents have the potential to affected if infection control practices not consistently followed. -All staff have been educated on in control program. Nursing staff have educated on proper procedure for infection control when changing ca collection bags. DNS has been ed on infection control tracking. -Random audits will be completed of infection control measures durin catheter collection bag changes. F infection control program will be re monthly to insure monitoring of org and resolution of infections is inclu Negative findings will be responsible -Corrective action will be complete 8/26/15.	nnique elling nen n R22¿s be s are fection re been theter ucated weekly g facility viewed janisms ded. at	

STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		245270	B. WING		07	/17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		/1//2015	
GOLDE	N LIVINGCENTER - W	HITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETIC DATE	
F 441	twelve residents hat the twelve resident identified. None of symptom resolution 2/2015, eight reside experienced possik residents had actua eight of the resident identified. All eight identified. All eight identified. One of to organisms identifie had symptom resol 3/2015, Ten resident experienced possik residents had actua the ten residents hat athe ten residents hat the ten residents hat the ten residents hat identified. None of symptom resolution 4/2015, Eleven res experienced possik eleven residents hat All eleven of the resi identified. All eleven identified. None of causal organisms in residents had symp 5/2015, Eleven res experienced possik eleven residents hat symp	ad antibiotic identified. None of s had causal organisms the twelve residents had n identified. ents in the facility had ble infections. Six of the eight al symptoms identified. All its had type of infection residents had antibiotic he eight residents had causal d. None of the eight residents lution identified. nts in the facility had ble infections. Six of the ten al symptoms identified. Nine of ad type of infection identified. d antibiotic identified. None of had causal organisms the ten residents had	F 4	141			

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ND PLAN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
				3		
		245270	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07	17/2015
	PROVIDER OR SUPPLIER N LIVINGCENTER - W					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ST CHARLES, MN 55972 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 441	identified. 6/2015, Partial listi Three residents in possible infections had actual sympto residents had type residents had antik three residents had None of the three resolution identifie The facility's policy dated 4/6/15 includ program designed sanitary and comfo to help prevent the of disease or infec facilities." Althoug further policy provi the infection contro During interview of registered nurse-A responsible for the program. RN-A ve Resident Infection system for infectio from 1/2015 to 6/2 monitoring of symp RN-A verified the i	ad symptom resolution ng of infections was provided. the facility had experienced . Two of the three residents ms identified. Two of the three of infection identified. All three biotic identified. None of the d causal organisms identified. residents had symptom d. y, Infection Control Program ded: "An infection control to provide and maintain a safe, prtable work environment and e development or transmission tion will be established for all h requested, there was no ded related to components of	F 441			

If continuation sheet Page 42 of 50

	-	AND HUMAN SERVICES			FORM	: 08/19/2015 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WI	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	was ajar with soiled that had been sitting the container. NA-F cart outside of R22' room. When asked NA-F responded by infection control iss linens should have NA-F then stripped without putting glov container to open it container, and then without putting glov container to open it container, and then without washing he outside of the cover cover down over the hand sanitizer locat and came back in ti NA-F completed the standard infection of During an interview stated R22 had VR Enterococcus) in ar healed on her abdo VRE was in her ost call nurse practition precautions could b should have washe gloves prior to hand touching the linen of NA should have the washed her hands The facility provided protective equipme the guidelines direct use gloves. A policy on storage	d linens touching two pillows g on top of chair adjacent to had a covered clean linen 's room. NA-F came into the about the overfull container, v explaining "that is an ue," she further explained the been removed from the room. the pillow cases off the pillow res on, touched the lid of the touched the linens inside the walked outside of the room r hands and touched the r of the linen cart to pull the e clean linens. NA-F used the ted outside the resident's room he room and put gloves on. e removal of the linens using	F 441			

Facility ID: 00942

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245270	B. WING		07/ <sup>-</sup>	17/2015
NAME OF	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	N LIVINGCENTER - WI	HITEWATER	-	25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	Continued From pa	ige 43	F 441			
	on 7/14/15, at 1:02 toilet, nursing assis catheter collection If was going to chang cap from the new u and draped the new lift that had been in remove a connection catheter. After the p used an alcohol wip touched the floor w soiled gloves touch not remove her glow hands. NA-C proce tubing of the collect to connect the cont bag. NA-C was stop new sterile tubing w collection bag was R12's quarterly Min 5/26/15 indicated m with a Brief Intervie score of 10, had a of had an indwelling F During an interview director of nursing ( should have taken of and the resident's of tubing should not hav mechanical lift. The facility provided Insertion and Removies	nimum Data Set (MDS) dated noderate cognitive impairment w for Mental Status (BIMS) diagnoses of dementia, and				

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			M APPROVED D. 0938-0391
		PLE CONSTRUCTION (X3) DA	ATE SURVEY DMPLETED
B. WIN	G		7/17/2015
		STREET ADDRESS, CITY, STATE, ZIP CODE	
PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
BL I I I I I I I I I I I I I I I I I I I	465		f D
	A. BUIL B. WIN PRE TA A. BUIL PRE TA CPRE TA CPRE TA CPRE TA TA CPRE TA CO CO CO CO CO CO CO CO CO CO CO CO CO	A. BUILDING B. WING B. WING PREFIX TAG F 465 ABL F 465 ABL IF 46	(X2) MULTIPLE CONSTRUCTION       (X3) DA         A. BUILDING

		AND HUMAN SERVICES				FORM	08/19/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245270	B. WING _			<b>07</b> / <sup>.</sup>	17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WI	HITEWATER		-	25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	were MM was not a when they were difficult clean them. When a were cleaned MM s further stated the fa Stand transfer lifts a recently. On 7/16/15, at 12:5 (DON) verified the I transfers lift in the 1 with ill repair. When was of staff DON st send the lift sheets they noticed it was stated she would ha report to her the lift indicated she had b not sure if the lift sh further stated the lift residents in the faci On 7/16/15, at 1:55 surveyor and stated sheets were cleane sent down to launda On 7/16/15, at 5:11 approached the sur residents that share and the manual lift. was a cleaning sche sheets were cleane schedule and stated supposed to be cleat acknowledged the l	able to indicated and stated ty laundry department would asked how often the lift sheets stated he was not sure. MM acility currently had two Sit to as one had gone down 3 p.m. the director of nursing lift sheet in the Sit to Stand 100 Wing was soiled and was n asked what her expectation tated she expected staff to to laundry for cleaning when not clean. In addition the DON ave expected the staff to sheet was in ill repair but been out of the facility and was neet had been ordered. DON ft sheets were shared amongst ility.	F 46	65			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
ID PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	IPLETED	
		245270	B. WING		07/	/17/2015	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
OLDEN	LIVINGCENTER - WI	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 465	Continued From pa	ae 46	F 4	65			
		p.m. a Sit to Stand transfer lift					
	was observed static	oned by the fire door in the 100					
	0	104 and the lift sheet which of the machine was still					
		ed even though the concern					
_		o the facility's attention.	_				
F 497	483.75(e)(8) NURS REVIEW-12 HR/YF		F 4	97		8/26/15	
SS=F							
		mplete a performance review					
		at least once every 12 provide regular in-service					
		the outcome of these					
		rvice training must be					
		the continuing competence of ust be no less than 12 hours					
		reas of weakness as					
		e aides' performance reviews					
		ne special needs of residents ne facility staff; and for nurse					
		vices to individuals with					
		nts, also address the care of					
	the cognitively impa	aired.					
	This REQUIREMEN	NT is not met as evidenced					
	by:			E 407			
		and document review, the ure 5 of 6 nursing assistants		F497 -Annual performance revi	ews have been		
		, NA-D, and NA-E) received		completed for nursing ass			
		e reviews. This had the		Continuing education hou			
		all 45 residents in the facility ory facility where staff work on		have worked at the facility months has been completed			
	all of the units.			-All residents have the por	tential to be		
	Findings included:			affected if performance ev continuing education are r			
	NA-A's personnel fi			staff.			

Event ID:4HCK11

Facility ID: 00942

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		1				
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245270	B. WING			07/	17/2015
ROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIVINGCENTER - W	HITEWATER					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	x	(EACH CORRECTIVE ACTION SHOU	D BE	(X5) COMPLETIC DATE
10/29/08. The dire during interview on there had been no evaluations complet NA-B's personnel f 1/7/13. The DON v 7/17/15 at 8:41 a.m annual performance NA-B since hire. NA-C's personnel f 9/23/13. During inte 7/17/15 at 8:44 a.m been no annual pe completed for NA-C NA-D's personnel f 10/4/13. During inte 7/17/15 at 8:48 a.m no performance ev employee. NA-E's personnel f 6/27/05. The DON 7/17/15 at 8:51 a.m annual performance NA-E in the past ye On 7/16/15, at 5:33 stated as far as he availabe for the nu provided. At 5:36 p	ector of nursing (DON) verfied a 7/17/15 at 8:35 a.m., that annual performance beted for NA-A. The revealed a hire date of rerified during interview on h., that there had been no be evaluation completed for file revealed a hire date of erview with the DON on h., the DON verified there had rformance evaluations C. file revealed a hire date of erview with the DON on h., the DON verified there were valuations available for the file revealed a hire date of verified during interview on h., the DON verified there were valuations available for the file revealed a hire date of verified during interview on h., that there had been no be evaluation completed for the evaluation completed for the facility's NA trainer was aware all the information rsing assistants had been b.m. registered nurse (RN)-D	F 4	97	training for employees. -Random audits will be completed monthly on performance reviews continuing education needs. Per- reviews and required annual train be completed timely. Negative re- be reviewed at QAPI. -DNS/designee will be responsibl	d and formance ing will isults will e.	
	OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LIVINGCENTER - W SUMMARY ST, (EACH DEFICIENC REGULATORY OR I Continued From pa 10/29/08. The dired during interview on there had been no evaluations completed NA-B's personnel f 1/7/13. The DON v 7/17/15 at 8:41 a.n annual performance NA-C's personnel f 9/23/13. During int 7/17/15 at 8:44 a.n been no annual pe completed for NA-0 NA-D's personnel f 10/4/13. During int 7/17/15 at 8:48 a.n no performance ev employee. NA-E's personnel f 6/27/05. The DON 7/17/15 at 8:51 a.n annual performance VA-E in the past ye On 7/16/15, at 5:33 stated as far as he availabe for the nu provided. At 5:36 p stated all the in-set	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:       245270         ROVIDER OR SUPPLIER       245270         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 47       10/29/08. The director of nursing (DON) verfied         during interview on 7/17/15 at 8:35 a.m., that       there had been no annual performance         evaluations completed for NA-A.       NA-B's personnel file revealed a hire date of         1/7/13. The DON verified during interview on       7/17/15 at 8:41 a.m., that there had been no annual performance evaluation completed for         NA-B's personnel file revealed a hire date of       9/23/13. During interview with the DON on         7/17/15 at 8:44 a.m., the DON verified there had been no annual performance evaluations completed for NA-C.         NA-D's personnel file revealed a hire date of         10/4/13. During interview with the DON on         7/17/15 at 8:48 a.m., the DON verified there were no performance evaluations available for the employee.         NA-E's personnel file revealed a hire date of         0/27/05. The DON verified during interview on         7/17/15 at 8:51 a.m., that there had been no annual performance evaluations available for the employee.         NA-E's personnel file revealed a hire date of         0/27/05. The DO	OF DEFICIENCIES FORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         PROVIDER OR SUPPLIER       245270       B. WING         ELVINGCENTER - WHITEWATER       B. WING         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       F 4         Continued From page 47       F 4         10/29/08. The director of nursing (DON) verified during interview on 7/17/15 at 8:35 a.m., that there had been no annual performance evaluations completed for NA-A.       F 4         NA-B's personnel file revealed a hire date of 1/7/13. The DON verified during interview on 7/17/15 at 8:41 a.m., that there had been no annual performance evaluation completed for NA-B since hire.       NA-C's personnel file revealed a hire date of 9/23/13. During interview with the DON on 7/17/15 at 8:44 a.m., the DON verified there had been no annual performance evaluations completed for NA-C.         NA-D's personnel file revealed a hire date of 10/4/13. During interview with the DON on 7/17/15 at 8:48 a.m., the DON verified there were no performance evaluations available for the employee.         NA-E's personnel file revealed a hire date of 6/27/05. The DON verified during interview on 7/17/15 at 8:51 a.m., that there had been no annual performance evaluation completed for NA-E in the past year.       On 7/16/15, at 5:33 p.m. the facility's NA trainer stated as far as he was aware all the information availabe for the nursing assistants had been provided. At 5:36 p.m. registered nurse (RN)-D stated all	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING.         245270       B. WING	OP DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         ARROWIDER OR SUPPLIER       245270       STREET ADDRESS, CITY, STATE, ZIP CODE S25 BLUFF AVENUE ST CHARLES, NN 55972         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION)       ID PROVIDER'S FLAND C CORRECTIVE (EACH OPRECTIVE ACTION SHOUL CROSS REFERENCED OF THE APPRO DEFICIENCY)         Continued From page 47 10/29/08. The director of nursing (DON) verified during interview on 7/17/15 at 8:35 a.m., that there had been no annual performance evaluations completed for NA-A.       F 497         Continued From page 47 11/7/13. The DON verified during interview on annual performance evaluation completed for NA-B's personnel file revealed a hire date of 9/23/13. During interview with the DON on 7/17/15 at 8:44 a.m., the DON verified there had been no annual performance evaluations completed for NA-C.       F 497         NA-D's personnel file revealed a hire date of 9/23/13. During interview with the DON on 7/17/15 at 8:44 a.m., the DON verified there were no performance evaluations available for the employee.       -DNS/designee will be completed for NA-E in the past year.         NA-E's personnel file revealed a hire date of 0/27/05. The DON verified during interview on 7/17/15 at 8:48 a.m., that there had been no annual performance evaluations available for the employee.       NA-E's personnel file revealed a hire date of 0/27/05. The DON verified during interview on 7/17/15 at 8:51 a.m., that there had been no annual performance evaluations completed for NA-E in the past year.       NA-E's personnel file revealed a hire date of 0/27/05.	OF DEFICIENCIES       (X1) PROVIDERSUPPLIENCLA DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DAT         PROVIDER OR SUPPLIEN       245270       IVING       07/         ROVIDER OR SUPPLIEN       INTECT ADDRESS, CITY, STATE, ZIP CODE       525 BLUFF AVENUE       07/         SUMMARY STATEMENT OF DEFICIENCIES       PROVIDERS NUM STATE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       PRECK TAGE       PROVIDER SUPPLIEN       PROVIDER SUPPLIEN         Continued From page 47       10/29/08. The director of nursing (DON) verified during interview on 7/17/15 at 8:35 a.m., that there had been no annual performance evaluations completed for NA-A.       F 497         NA-B's personnel file revealed a hire date of 17/13. The DON verified during interview on 7/17/15 at 8:41 a.m., that three had been no annual performance evaluations completed for NA-C.       F 497         NA-C's personnel file revealed a hire date of 10/4/13. During interview with the DON on 7/17/15 at 8:44 a.m., the DON verified three had been no annual performance evaluations completed for NA-C.       F 497         NA-E's personnel file revealed a hire date of 10/4/13. During interview with the DON on 7/17/15 at 8:43 a.m., the DON verified three were no performance evaluations available for the employee.       F 497         NA-E's personnel file revealed a hire date of 6/27/05. The DON verified during interview on 7/17/15 at 8:43 a.m., that three had been no annual performance evaluation completed for NA-E's nersonnel file revealed a hire date of 6/27/05. The DON verified during interview on 7/17/15 at 8:43 a.m., that there had

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		AND HUMAN SERVICES			FORM	: 08/19/2015 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245270	B. WING		07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - WH	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 497	(ED) stated her exp be in compliance wirequirements. On 7/17/15 at 10:43 surveyor and stated	ago. a.m., the executive director bectation was for the facility to with the regulatory 3 a.m., RN-D approached the d the facility did not have a v policy but would be expected	F 497	7		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN A facility must main	IBERS/MEET	F 520	ז		8/26/15
	nursing services; a	physician designated by the 3 other members of the				
	committee meets a issues with respect and assurance activ develops and imple	ment and assurance It least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.				
	disclosure of the re- except insofar as su	retary may not require cords of such committee uch disclosure is related to the committee with the s section.				
		s by the committee to identify deficiencies will not be used as ns.				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245270	B. WING		<b>07</b> /1	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From pa	ge 49	F 520			
	by: Based on interview failed to have the re Quality Assessmen (QAA) at least qua had the potential to resided in the facilit Findings include: Review of the facilit record reviewed fro the medical director on 7-30-14, 10-15-1 attendance record r attended the QAA n On 07/17/2015 9:1 (DON) stated based meeting attendance medical director (M meetings in the last attendance records	NT is not met as evidenced y and record review, the facility equired members attend the t and Assurance Committee rterly. This deficient practice affect all 45 residents who y at the time of the survey. y's QAA meeting attendance m 7-30-14 to 4-15-15 revealed r attended the QAA meetings 14 and 4-15-15. The revealed no physician neeting held on 1-2-15. 7 a.m. the director of nursing d on the documentation of e for QAA meetings the D) did not attend quarterly is year. The DON verified the reflected MD had not quarterly review meeting.		F520 -QAA meetings are being held at lequarterly. -All residents have the potential to a ffected if QAA meetings are not he least quarterly to identify areas for improvement. -Department managers have been educated in QAA requirements. -Monthly audits will be conducted to insure QAA meetings are held per of requirements with the required atter -Physician educated on 8/13/15 in to quarterly QAA attendance regula -Physician will attend QAA at least quarterly via telephone conference person. -ED/designee will be responsible. -Corrective action will be completed 8/26/15.	be eld at CMS ndees. regards ttion. or in	

If continuation sheet Page 50 of 50

PRINTED: 08/19/2015

		AND HUMAN SERVICES	FF	1270023	FORM APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391 (X3) DATE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMPLETED
		245270	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07/14/2015
NAME OF F	PROVIDER OR SUPPLIER			525 BLUFF AVENUE	
GOLDEN	LIVINGCENTER - WI	HITEWATER	1	ST CHARLES, MN 55972	
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE DATE
					e
K 000	INITIAL COMMENT	ſS	K 000		
	FIRE SAFETY				
		OC WILL SERVE AS YOUR COMPLIANCE UPON THE			
	DEPARTMENT'S A	CCEPTANCE. YOUR			
		IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS			
	VERIFICATION OF				
	UPON RECEIPT O	F AN ACCEPTABLE POC, AN			
	ON-SITE REVISIT	OF YOUR FACILITY MAY BE			
		MPLIANCE WITH THE			
-		AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departm	Survey was conducted by the nent of Public Safety - State			
		on. At the time of this survey, er Whitewater was found not			
	- 0	liance with the requirements			
		Aedicare/Medicaid at 42 CFR,	8		
		Life Safety from Fire, and the ional Fire Protection			
		Standard 101, Life Safety			
		er 19 Existing Health Care.		EPO	
8	PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY			' 💙 📗 👘
	DEFICIENCIES				
	( K-TAGS) TO:				
	Lealth Core Fire In	enections			
	Health Care Fire In State Fire Marshal				
	445 Minnesota St.,	Suite 145			
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
Electron	ically Signed				08/14/2015

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

PRINTED: 08/27/2015

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01		E SURVEY IPLETED
				JUI - MAIN BUILDING UI		
		245270	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	14/2015
	I LIVINGCENTER - WI	HITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	Continued From pa St Paul, MN 55101	-	K 00	D		
	By email to: Marian.Whitney@s Angela.Kappenmar					
		RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION:				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.				
	2. The actual, or pro	oposed, completion date.				
		r title of the person ection and monitoring to ence of the deficiency.				
	building. The buildin different times. The constructed in 1967 was determined to In 1969, an addition Wing that was dete construction, with a original building and same type of const construction type a	er Whitewater is a 1-story ng was constructed at 2 original building was 7, with a partial basement and be of Type II(111) construction. In was constructed to the West rmined to be of Type II(111) full basement. Because the d the 1 addition are of the ruction and meet the lowed for existing buildings, reyed as one building.				
	fire alarm system w and spaces open to monitored for autor notification. The fac	sprinklered. The facility has a vith corridor smoke detection the corridors that is natic fire department cility has a capacity of 55 beds of 46 at the time of the survey.				

Service and Annual Property of the

Facility ID: 00942

If continuation sheet Page 2 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES				DRM APPRO NO. 0938-0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3 - MAIN BUILDING 01	) DATE SURVE COMPLETED	Y
		245270	B, WING			07/14/201	5
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W	HITEWATER			BLUFF AVENUE CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5 COMPLE DAT	IOITE
K 000	Continued From pa	ae 2	кс	000			
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is need by:					
K 018 SS=D		FETY CODE STANDARD	KC	)18		8/31/1	5
	required enclosures hazardous areas a	orridor openings in other than s of vertical openings, exits, or re substantial doors, such as					
	wood, or capable o minutes. Doors in required to resist th	of 1 <sup>3</sup> / <sub>4</sub> inch solid-bonded core f resisting fire for at least 20 sprinklered buildings are only be passage of smoke. There is					
	are provided with a the door closed. D	ne closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6 9.3.6.3					
	Roller latches are p in all health care fa	prohibited by CMS regulations cilities.					
	Based on observation	s not met as evidenced by: tion and staff interview, the a corridor door that meets the			K018: The maintenance director has added an additional electronic		
	requirements of NF	PA 101 LSC (00) Section icient practice could affect 15			preventative maintenance procedure to will advise him to check all doors for proper closure of shutting and latching This task will ask to have this done on monthly basis. Doing this will ensure to	j. ⊧a	
	Findings include:				all doors in the facility will consistently shut and latch to provide resident and		
	On facility tour betw	veen 0745 AM and 10:30 AM			staff safety.		

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Event ID: 4HCK21

Facility ID: 00942

If continuation sheet Page 3 of 8

PRINTED: 08/27/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMF	PLETED
		245270	B. WING		07/1	4/2015
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	I LIVINGCENTER - WI	HITEWATER	1	525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
K 018	on 07/14/2015, it w	ge 3 as observed that the kitchen - orridor will not shut/ and latch.	K 018	3		
K 029 SS=D	Facility Maintenanc discovery. NFPA 101 LIFE SA One hour fire rated	ice was confirmed by the e Director (JM) at the time of FETY CODE STANDARD construction (with ¾ hour an approved automatic fire	K 029			8/31/15
	extinguishing system and/or 19.3.5.4 pro- the approved autom option is used, the a other spaces by sm doors. Doors are s field-applied protect	m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from toke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are				
	Based on observat facility failed to main partitions and doors following requirement	s not met as evidenced by: tion and staff interview, the ntain smoke-resisting in accordance with the ents of 2000 NFPA 101, the deficient practice could dents.		K029: The maintenance director ha added an additional preventative maintenance procedure that will adv him to check all doors for proper clo of shutting and latching. This task w to have this done on a monthly basis Doing this will ensure that all doors i	vise sure ill ask s. in the	
	Findings include:			facility will consistently shut and latcl provide resident and staff safety.	n to	
	on 07/14/2015, obs	veen 0745 AM and 10:30 AM ervation revealed, that the e room # 3 (over 50 sq.ft.) will				

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Facility ID: 00942

If continuation sheet Page 4 of 8

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245270	B. WING		07/	14/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN		HITEWATER		25 BLUFF AVENUE T CHARLES, MN 55972		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
K 029	Continued From pa not shut and latch	ge 4	K 029			
	This deficient pract Facility Maintenanc discovery.	ice was confirmed by the e Director (JM) at the time of				2
K 050 SS=F	NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part o Responsibility for p assigned only to co qualified to exercise conducted between	FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is impetent persons who are the leadership. Where drills are to 9 PM and 6 AM a coded by be used instead of audible	K 050			8/31/15
	Based on documer interview, the facilit were conducted on staff under varying required by 2000 N This deficient pract residents. Findings include: On facility tour betw on 07/14/2015, the	s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 46 veen 0745 AM and 10:30 AM review of the fire drill the past 12 months (July 2014 aled the following:		K050: The maintenance director make sure that a fire drill is perfor each shift every quarter. The mai director will adjust the timing of ea drill conducted, making sure that dates the fire drill is performed is out during each month. Additiona time the drill is performed during shift will be spread out into 2 hou increments. The maintenance dir and the executive director will dis schedule of each fire drill at the b of every month to ensure proper the fire drill takes place.	rmed on ntenance ach fire the spread lly, the each r ector cuss the eginning	

Facility ID: 00942

If continuation sheet Page 5 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION () G 01 - MAIN BUILDING 01	(3) DATE SURVEY COMPLETED
		245270	B. WING		07/14/2015
	PROVIDER OR SUPPLIER	HITEWATER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 050 K 076 SS=D	Quarter of 2014 2. Did not sufficien drills were conducte a. evening - 150 hours b. night - 0200, These deficient pra Facility Maintenance discovery. NFPA 101 LIFE SA Medical gas storage protected in accord for Health Care Face (a) Oxygen storage 3,000 cu.ft. are end separation.	htly vary the times that the ed on the following shifts 20, 1810, 1445 and 1909 , 0130, 0430 and 0230 hours actices were confirmed by the re Director (JM) at the time of FETY CODE STANDARD e and administration areas are ance with NFPA 99, Standards	K 05		8/31/15
	Based on observat medical gas cylinde conformance with N Chapter 4, Section practice could all 6 FINDINGS INCLUE	s not met as evidenced by: tion, the facility was storing ers in a manner not in NFPA 99 (1999 edition) 4-3.5.2.2 (2). This deficient out of 46 residents. DE: veen 0745 AM and 10:30 AM		K076: The Maintenance Director will clear instructions in the oxygen room storage. A training session for all stat handle oxygen tanks will take place t educate them on the new procedure. signature page will be created for the training and will be kept in the Life Sa binder under the Oxygen Safety tab. maintenance director will conduct au	as to ff who o A afety The

Event ID: 4HCK21

Facility ID: 00942

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		6 01 - MAIN BUILDING 01	COMPLETED	
		245270	B. WING		07/	14/2015
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER		525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
K 076	floor oxygen storag	ge 6 ervation revealed that the 1st e room has empty and full "E" not segregated from each	K 076	weekly during his morning rounds sure that empty/full tanks are prop separated.		
K 144 SS=D	Facility Maintenanc discovery. NFPA 101 LIFE SA Generators are insp	ice was confirmed by the e Director (JM) at the time of FETY CODE STANDARD pected weekly and exercised hinutes per month in FPA 99. 3.4.4.1.	K 144			8/31/15
	Based on document interview, the facility emergency generative requirements of 200 NFPA 110 Chapter practice could affect Findings include: On facility tour betwo on 07/14/2015, doc 12 months (August logs, revealed that	s not met as evidenced by: ntation review and staff y failed to inspect the for in accordance with the D0 NFPA 101 - 9.1.3 and 1999 6 4.4(d). The deficient at all 46 residents. yeen 0745 AM and 10:30 AM umentation review of the past 2014 to July 2015) generator (7 out 12 months) there was for the minimum of 5 minute		K144: The maintenance director make sure that the generator runs an additional 5 minutes after the k transferred back to the building du monthly load testing. An additiona has been added to the monthly ge test report in Building Engines. Th asks for the minutes of cool down be entered on the report. If a time entered that is less than 5 minutes give the maintenance director and and will ask him to correct it before closes the task.	a t least bad has ring the l line nerator is result time to is s, it will error	

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

Facility ID: 00942

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/27/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245270	B. WING			07/ <sup>•</sup>	14/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER			25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144		ge 7 he emergency generator.	K.	144			
14		ice was confirmed by the e Director (JM) at the time of					
	*TEAM COMPOSI						
		fe Safety Code Spc.					
				))			

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

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Facility ID: 00942

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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 5, 2015

Ms. Margaret Holm, Administrator Golden Livingcenter - Whitewater 525 Bluff Avenue St Charles, Minnesota 55972

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5270024

Dear Ms. Holm:

The above facility was surveyed on July 13, 2015 through July 17, 2015 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Golden Livingcenter - Whitewater August 5, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Vate Compton

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00942	B. WING		07/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HIIEWAIER	F AVENUE LES, MN 55	972		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	PER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/14/15

Electronically Signed

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If continuation sheet 1 of 51

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00942	B. WING		07/	07/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	I LIVINGCENTER - W	HITEWATER	FF AVENUE				
GOLDEN		ST CHAI	RLES, MN 559	72			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic bcess, under the heading he date your orders will be electronically submitting to the nent of Health.					
	this Department's s and the following c Please indicate in y correction that you	i, 16 & 17, 2015 surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, te when they will be completed					
	the State Licensing federal software.	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMI "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. NB ON FACH PAGE					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		00942	B. WING	NG (	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 55	972	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	ige 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and tee	2 255		8/31/15
	assessment and as of the administrator services, the medic designated by the r three other member representing discip resident care. The assurance committ respect to which quinecessary and dev appropriate plans of quality deficiencies address, at a minim	ust maintain a quality ssurance committee consisting r, the director of nursing cal director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with iality assurance activities are elop and implement of action to correct identified . The committee must num, incident and accident control, and medications and			
	by: Based on interview failed to have the re Quality Assessmen (QAA) at least qua had the potential to	ent is not met as evidenced and record review, the facility equired members attend the t and Assurance Committee rterly. This deficient practice affect all 45 residents who ty at the time of the survey.		Corrected.	
	Findings include:	hu's QAA meeting attendance			
	record reviewed fro	ty's QAA meeting attendance om 7-30-14 to 4-15-15 revealed r attended the QAA meetings	Ł		

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/	17/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
OLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 255	Continued From pa	age 3	2 255			
	attendance record	14 and 4-15-15. The revealed no physician meeting held on 1-2-15.				
	(DON) stated base meeting attendance medical director (M meetings in the las attendance records	17 a.m. the director of nursing of on the documentation of e for QAA meetings the ID) did not attend quarterly t year. The DON verified the s reflected MD had not 5 quarterly review meeting.				
	The administrator of his/her representat	THOD OF CORRECTION: could educate the physician or ive on the importance of activities. Monitoring for to be included too.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			8/31/15
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and withir	A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal n representative at least n seven days of the revision of e resident assessment required subpart 3, item B.				
	This MN Requirem	ent is not met as evidenced				

4HCK11

If continuation sheet 4 of 51

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE	5972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 4	2 570			
		y, and document review, the late the plan of care for 1 of 2 viewed for falls.		Corrected.		
	Findings include:					
	readmitted on 6/16 cerebral artery occ hemiplegia affectin cerebral vascular o due to stroke). Upo	ed to the hospital on 6/4/15, /15 with primary diagnoses of lusion with infarct (stroke), g non-dominant side due to disease (left sided weakness on readmission R45's care plan o reflect his current functioning fall on 6/29/15.	ז			
	6/29/15 revealed F plus person physic transfers, walking i dressing and toilet the unit required ar physical assist. Fur	num Data Set (MDS) dated 45 required an extensive two al assist for bed mobility, n room, personal hygiene, use. Locomotion on and off n extensive one person nctional limitation revealed side for both upper and lower				
	not match the MDS need for assistance revision 5/29/15, in assist to ambulate independent mobili ambulate with nurs without assistive de	ided was not correct and did S and did not reflect the current e. Care plan dated 2/5/15, idicated R45 was a one persor to/from the bathroom, ity in room, and R45 should sing two to three times daily evice and a stand by assist of r guide was found not to match	n			
	and the Director of	a.m. Registered Nurse (RN)-A Nursing (DON) verified care surveyor is most current care				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/17/2015	
	PROVIDER OR SUPPLIER I LIVINGCENTER - WI	HITEWATER 525 BLU	DDRESS, CITY, S FF AVENUE RLES, MN 559			
(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 DEFICIENC <sup>\</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	ge 5	2 570			
	plan is conflicting, r	he information on the care esident is not independent, ncorrect information.				
	The director of nurs develop and implem related to care plan designee, could pro staff related to the t revisions. The quali	HOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures revisions. The DON or ovide training for all nursing imeliness of care plan ity assessment and assurance erform random audits to				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and e; General	2 830			8/31/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	<b>1</b> t			
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to ensure the facility		Corrected.		

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	for 1 of 1 resident (	cian orders to prevent edema (R33) reviewed who had a or antiembolism stockings.				
	Findings include:					
	minimum data set congestive heart fa (HTN), diabetes mo	ere identified on the quarterly (MDS) assessment to include: ilure (CHF), hypertension ellitus (DM), cerebrovascular mentia and atrial fibrillation.				
	Signature Form rev which directed "Ne	nysician's Orders And /ealed an order dated 7/7/15, eds Tubigrips or Compression norning), off PM (evenings) na."				
	wheeled down the family member (F1 visiting. R33 was o and he had on ank At the time of the o ankles were uncov swollen as F1 took a.m. F1 was obser put the TV (televisiv visible swelling of t	a.m. R33 was observed being hallway towards the desk by a ) who was at the facility bserved wearing sweat pants, le socks and house slippers. bservation both of R33's ered and were noted to be him into his room. At 9:13 ved in R33's room helping to on) on. Although R33 had he ankles, R33 was not to be wearing the compression				
	the dining room (D the table eating lun either Tubigrips or	26 p.m. R33 was observed in R) seated in his wheelchair at ich. R33 was not wearing the compression stockings at till wearing the ankle socks. ined swollen.				
		9 a.m. and again at 9:03 a.m., seated on his wheelchair at				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00942	B. WING		07/	07/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	172			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLET	
TAG	i.	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
2 830	Continued From pa	age 7	2 830				
	stockings nor Tubig	was not wearing compression grips but was wearing black ankles were uncovered and be swollen.					
	was interviewed ab dated 7/7/15, to ap stockings for R33 v	a.m. registered nurse (RN)-D out whether or not the order ply Tubigrips or compression vas current. RN-D stated she she was done with the on pass.					
	(DON) stated she h therapy departmen ordered the stockin had a staff person stockings may have asked if the stockin the DON stated, "if	Y a.m. the director of nursing had talked to staff in the t and learned that they had hgs. She further stated she checking whether the e been sent to laundry. When hgs were sent to laundry daily they were soiled the staff own because they aren't able e sink."					
	stated, "For months stockings. We can swollen and we ele never seen them."	8 a.m. nursing assistant (NA)-F s he has not had TED (elastic) only tell the nurse the legs are vate them. I help him and have NA-F verified R33's legs were R33 routinely wore ankle					
	ordered the compre the stockings would own system and no indicated at the fac person designated executive director of go in and accept the	3 a.m. when asked who ession stockings RN-D stated d be ordered from the facility's of from the pharmacy. RN-D ility level there would be a to make the orders the or DON would be the ones to be order placement. When staff responsible for ordering					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		
		00942	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	172		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 8	2 830			
	the stockings was staff had called in s	available, the ED stated the sick for the day.				
	surveyor and state Tubigrips are being stockings have been acknowledged the	order for the compression been completed until now and				
	would expect the o stockings for this c followed up to mak applied. I expected implemented." The	29 a.m. the DON stated, "I order to be done and the ase to have been ordered and the sure they were delivered and the order to have been to DON acknowledged the sings had not previously been				
	impaired cardiovas and atrial fibrillation to observe for, and edema, shortness	ted 3/20/14, indicated R33 had scular status related to HTN n. The care plan directed staff I report, signs of chest pain, of breath and to elevate the tremities as indicated.	1			
	(Elastic Stockings) purpose of the stoc prevent embolus for	for Anti-embolism Stockings , dated 2006, indicated the ckings was to reduce edema, ormation, to aid return ver extremities and to provide er extremities.				
	record review, the appropriate interve eating assistance a food/fluids in order	on observation, interview and facility failed to implement intions including supervision, and/or appropriate textured to prevent choking/aspiration or 2 of 2 residents (R12, R51)				

	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	I LIVINGCENTER - W	HITEWATER 525 BLU	FF AVENUE			
		ST CHAF	RLES, MN 559	)72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 9	2 830			
	failure to implement in an immediate jeor R51. The immediate jeor it was first observent the necessary super and food consistent meal service obsert administrator, a contain from the corporate immediate jeopard 2015 but noncompt scope and severity and severity level, with potential for most immediate jeopard 2015 but noncompt scope and severity and severity level, with potential for most immediate jeopard 2015 but noncompt scope and severity and severity level, with potential for most immediate jeop Findings include: R12 and R51's medical record aspiration pneumon the time of admissi having a diagnosis swallowing). Althous specific intervention assistance, and most to ensure these intervention assistance and the fill assistance assistance as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a state as a	a clinical services specialist office were notified of the y at 5:32 p.m. on 7/14/15. The y was removed on July 16, liance remained at the lower level of D - isolated, scope which indicated no actual harm ore than minimal harm that is				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.	·····		
		00942	B. WING		07/17/2015	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - W	HITEWATER				
		SI CHAP	RLES, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 10	2 830			
	residents in the din handed R12 a wipe not ask R12 if he w having difficulty sw At 6:52 p.m. on 7/1 cough while eating more violent and a spewed from his m available in the imm turned red as he co nurse (RN)-B came after the coughing RN-B removed R12 dining room while h was taken out to th the dining room an been served. RN-E R12 had received w and that the substat than pudding thick' At 7:04 a.m., R12 w the lobby at a small had stopped cough returned to normal, towards the wall m staff who might be tray brought out an R12 was left unsup were in the direct w practical nurse (LP at a medication can back to R12. At 7:1 lobby area alone. A was observed to ap dinner tray at 7:13 asked CP-A wheth training to assist re	sing out wipes to other ing room came over to R12, e and left the area. NA-C did vas okay, or whether he was allowing the hot chocolate. 3/15, R12 again began to . This time the cough was pinkish/red colored liquid oouth. There were no staff nediate area, R12's face ontinued to cough. Registered e to the table about 2 minutes had started and at 7:00 p.m., 2 (in his wheelchair) from the ne continued to cough. R12 ie lobby. RN-B then re-entered d asked about what R12 had 8 stated the red apple sauce was considered pureed fruit, ance in the glass was a "thicker ' fluid. was observed seated alone in I table against the wall. He ning and his face color had . R12 was noted to be facing aking him less easily visible by in the area. RN-B had his food d placed in front of him. Again pervised with his meal. No staff icinity of R12, a licensed N)-A, was observed standing t 15-20 feet away with her 1 p.m. R12 remained in the A clinical psychologist (CP)-A oproach R12 to remove his p.m. At that time, the surveyor er she'd had any formal esidents with eating. CP-A had any training for assisting				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			
		00942	B. WING		07/17/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - W	/HITEW/ATER	FF AVENUE RLES, MN 559	172		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	resident. During a breakfast at 9:03 a.m., R12 v dining room table v	urveyors were watching the meal observation on 7/14/15 was observed to sit at the with his breakfast tray in front o	f			
	or observed to be a took a bite of crear for approximately 3	o staff sitting with the resident supervising the resident. R12 m of wheat, held it in his mouth 3 seconds and began to cough				
	run down his chin. observed to come wanted a napkin.	red to drip out of his mouth and At 9:05 a.m. NA-C was over to R12 and whether he NA-C was heard to instruct wallow." NA-C stayed at R12's				
	sat down at anothe resident. At 9:09 a his breakfast, he w	<ul> <li>when she left R12's table and er table to feed a different</li> <li>m. As R12 continued to eat /as observed to take several old it in his mouth for long</li> </ul>	ŀ			
	use the chin-tuck p staff monitor R12 v eating/chewing/sw	allowing or cue him to use the				
	R12's table until 9: During an interview	e. NA-C did not return to 13 a.m. v on 7/14/15, at 9:24 a.m. an (RD)-A explained the				
	baseline consisten applesauce, but ve and fluids for R12	cy for pureed food is erified the consistency of food should be pudding thick A stated thickener should be				
	added as needed t consistency was p ordered. RD-A also	to R12's food and fluid repared as the physician had o stated, "people who have				
	aspiration precauti supervision in the	ons, including R12, need direct dining room."				
	p.m., R12 sat at th	n of lunch on 7/14/15 at 12:34 e table with a spoon in his ere present at the table or in				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	072		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	tray included puree thick consistency. During an interview dietary assistant (E determined the cor sticking a spoon in stands straight up, pudding thick. DA- served R12's carro consistency. Following the facilit was observed at 6: supper meal. R12 and was moaning b between R12 and b take a heaping spot Although RN-B ins bites, she did not in chin and swallow. I hold the cranberry approximately 7 set took another bite th bite, and was again mouth for several s bites and each time seconds in his mout Throughout the ob- encourage R12 to 6:32 p.m. RN-B pic attempted to feed f observation RN-B R51 with eating. W R12 resumed feed returned to assist F food on the spoon while there was stil food running out of to hold food in his foot	during this time. R12's meal ed carrots served at a honey y on 7/14/15 at 2:27 p.m., DA)-A stated the dietary staff hisistency of R12's food by the food, and if the spoon it would be considered A acknowledged she had ots without having verified the ty's notification of the IJ, R12 :10 p.m. on 7/14/15 at the was seated at the dining table loudly. RN-B was sitting R51. R12 had attempted to conful bite of cranberry juice. tructed R12 to take smaller histruct the resident to tuck his instead, R12 was observed to juice in his mouth for econds before swallowing. R12 hat was smaller, chewed the h observed to hold it in his seconds. R12 took four more e held the food for several uth before swallowing. servation, RN-B did not use the chin-tuck technique. At cked up R12's spoon and him. At 6:33 p.m. During the was also observed to assist Vhile RN-B was assisting R51, ing himself. When RN-B R12, she was observed to put and place bites in R12's mouth. If food in R12's mouth. R12 had f his mouth, and was observed mouth at the same time. No wided for R12 to use chin-tuck	1			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING	B. WING		17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	172		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	to take a bite and t cried out "Ahh" and then closed his mo when he opened h of tan colored liquid his clothing protect removed from the area. During an interview 7/14/15, RN-B told experienced a brie room. RN-B stated assistants had inte several bites of foc When the surveyor much food in his m eating right along a swallowing but he pretty close." On 7/14/15, at 8:01 and administrator w noted during the su During an observa 7/15/15, at 8:20 a.r dining room table w the table. Although consistency bevera spoon and attempt cranberry juice from the table and only g take smaller bites. the table without as bites of food, and w present with R12 to At 8:26 a.m. the su	<ul> <li>6:39 p.m. R12 was observed o hold it in his mouth. R12</li> <li>d then began to cough. R12</li> <li>buth for a few seconds and is mouth again, a large amount d drained out of his mouth onto tor. At 7:15 p.m. R12 was</li> <li>dining area and set in the lobby</li> <li>w with RN-B at 7:21 p.m. on d the surveyor R12 had f choking episode in the dining she and two nursing</li> <li>rvened. RN-B stated R12 had od in his mouth at the time.</li> <li>r inquired, "How did he get that nouth?" RN-B stated, "He was and I thought he was</li> <li>didn't swallow. I was watching</li> <li>I p.m. the director of nursing were informed of the concerns upper meal with R12.</li> <li>tion of the breakfast meal on m. R12 had been sitting at the with no staff member present a R12 was served the correct ages, when R12 grabbed his red to remove a heaping bite of m the glass, RN-B walked by gave a verbal cue for R12 to RN-B then walked away from ssisting R12 to take smaller without ensuring staff were o supervise as he ate his meal.</li> </ul>	t			
	supervise the resid thickened drinks he	that there was no one to lent as he attempted to eat the e had been served. At 8:27 served to sit down between				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
GOLDE	N LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	972		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	because the drinks the table" At 8: in front of him, and bite, he experience time, RN-A gave ve chin tuck procedure observed to assist down next to R51, moved to the other another resident, th table to wash her h table, RN-A also go side of the table to leaving R12 without returned to the table side with her back couple of bites of fo were observed to of point the surveyor of the concern with while independentl with R12 at 8:58 a. meal. R12 was admitted according to the fa diagnoses that incl dementia with beha (difficulty swallowin hearing loss, and a R12's quarterly Min 5/26/15, indicated impairment with a I Status score of 10 The MDS indicated responded adequa communication. In R12 experienced of meals or when swa	stated, "I am sitting here were prematurely delivered to 36 a.m. R12's meal was placed as he independently took a ed a coughing incident. At that erbal cues to R12 to follow the e. At 8:39 a.m. RN-A was R51. At 8:41 a.m. NA-G sat however at 8:45 a.m. NA-G side of the table to assist nen walked away from the hands. When NA-G left the of up and moved to the other assist the other resident at any assistance. NA-G le, however sat on the other to R12. After R12 had taken a ood, copious amounts of saliva drain from his mouth. At that intervened and informed RD-A n R12 not being supervised y eating. RD-A got RN-B to sit m. until R12 had completed his to the facility on 9/3/14 cility admission record with uded but were not limited to: avioral disturbance, dysphagia ng), esophageal reflux, central anxiety disorder. himum Data Set (MDS) dated R12 had moderate cognitive Brief Interview for Mental which indicates confusion. d R12 had unclear speech, but tely to simple direct addition, the MDS indicated coughing and/or choking during allowing medication, and rvision and assistance with				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	79		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
2 830	Continued From pa	age 15	2 830			
	6/12/15, indicated I and required thicked included, "Puree no white rice, no m ongoing difficulties The record also indi- speech therapy set 5/6/15, for medical vascular accident a Therapy notes indit 4/6/15- "R12 choked session, had delay In addition, the note given to staff on ho seconds to elicit sw meats if needed, at 4/7/15- "education food from the resid spoon for liquids." 4/8/15-"required ma verbal cues to use related to coughing of coughing related addition the treatm does not appear to self-feeding, at this care] with increase risk of aspiration." 4/9/15- The note in in his mouth and re visual cues to swal the resident had 3 became anxious. The speech therap communicated on a Recommendations with honey thick liq	rition assessment dated he had a swallowing disorder ened liquids. The assessment diet with pudding thick liquids, ilk with mealsr/t [related to] with swallowing" dicated R12 had received rvices from 2/18 through diagnoses of: cerebral and treatment for dysphasia.				

	NT OF DEFICIENCIES I OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	bite, use a spoon for (help with bite size On 4/13/15 speech order from honey the liquids. 4/15/15 - "educat compensatory strat taking small bites a sips, avoid slurping sitting upright, chin flexion, etc.) to ass R12 had increased himself, and educat need for increased case of aspiration of 4/23/15 - "maxim Coming out right si side. Verbally walk [technique]." R12's care plan wa 7/14/15. The care p difficulty swallowing accident. The care p dif	w, clear mouth prior to next or drinks, and take small bites as needed)." In therapy had changed the hick liquids to pudding thick tion was given to staff for cuing tegies (these would include and sips, alternate bites and g and drinking through straws, tuck also known as head ist R12 in swallowing safely, I coughing when he fed tion was given to staff 'on supervision during meals' in or airway blockage." um anterior oral spillage. de. Max pocketing on right ed him through swallow as provided by the facility on oblan indicated R12 had g related to a cardiovascular plan interventions included for visician ordered diet of pureed liquids, no white rice, and no ne care plan further instructed to follow SLP [speech ist] recommendations, monitor eals, eating assistance of 1, ] to attempt to feed self with ded." The care plan had not slude the SLP's specific identified on 4/10/15. at 9:13 a.m. 7/14/15, during to be sitting at the dining table ependently. R51 was observed cened fluids, scrambled eggs 'e was not a staff person at the				

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00040	B. WING		07/	17/0015
		00942			07/	17/2015
	PROVIDER OR SUPPLIER	525 BLU	DRESS, CITY, ST <b>FF AVENUE</b>	IATE, ZIP CODE		
OLDEN	LIVINGCENTER - W	HITEWATER	LES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	take a bite of oatm immediately R51 b observed to take a again coughed sew dining room were a did not check on R coughing episodes assistant, (NA)-C, did not intervene for tablemate's with ea During an evening at 6:13 p.m. R51 w dining room table of honey thickened ho (RN)-B sat betwee R51's food, which a appropriate consist him. From 6:23 p.m independently with RN-B. R51 was of to take additional b was in his mouth. A face R51 and instru- bites. At that time of R51's plate and into R51's lap with R51's plate. At 7:0 and his face turned needed to stop cou- bite. R51 waited un then took a drink, a times but did not tu another drink and a however staff did n the chin tuck proce	meal observation on 7/14/15, vas observed seated at the drinking what appeared to be of chocolate. Registered nurse n R51 and R12. At 6:23 p.m. was observed to be the tency, was placed in front of n. to 6:28 p.m. R51 ate out any verbal cues from oserved to take large bites, and ottes before swallowing what At 6:28 p.m. RN-B turned to ucted R51 to take smaller R51 moved the food to center removed food that had fallen a fork, and placed it back onto 1 p.m. R51 started to cough d red. RN-B instructed R51 he ughing before taking another ntil the coughing had stopped and again coughed several urn red. At 7:08 p.m. R51 took again began coughing, iot give any verbal cues to use edure prior to swallowing.				
		4/15, the director of nursing 1 out of the dining room in his				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	172		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	wheelchair and platelevision and gave twice, as the DON was observed to stapproximately 30 sclear liquid drained used the tissue to vice ased after R51 vice During an interview 7/14/15, following to "towards the end sputtering, so I pat coughed and got it alright, you can hear she could tell it had can tell that he clear hear it gurgling any During an observar 7/15/15, at 8:20 a.r sitting at the dining present at the table beverages of the cc began to drink inder supervision. RN-B table and provide vice offer any cues or a At 8:26 a.m. on 7/1 about R51 having n staff availability to a was not sure how to a.m. RN-A sat betw "I am sitting here b prematurely deliver R51's meal was plat a.m. NA-G sat next	ced him in front of the e him a tissue. R51 coughed walked away. At 7:13 p.m. R51 cart coughing again, and after seconds his face turned red, I from his mouth, and R51 wipe his face. The coughing viped his face. The coughing viped his face. v with RN-B at 7:21 p.m. on he evening meal, RN-B stated, of the meal he [R51] started ted him on the back and he out of his throat, so he's ar it cleared." When asked how d cleared, RN-B stated, "You ared it because you couldn't more." tion of the breakfast meal on m. R51 was again observed room with no staff members e. R51 was served the orrect consistency which he ependently without staff was observed to walk by the verbal cues to R12, but did not		DEFICIENC	Υ)	

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
			A. BOILDING.				
		00942	B. WING		07/17/2015		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 19	2 830		- ' )		
	who was also sittin and said, "Tell him NA-G looked at R5 bites. At 8:45 a.m. to assist his tablem independently with walked away from At the same time, I other side of the ta When NA-G return opposite side from continued to assist back to R51. From was observed to ea observed to take la bite taken. At 8:58 face turned red, R1 it would be good to adequate chair pos R51's record was r face sheet indicate the facility on 11/5/ the facility admissio included: dysphagi problems with swa (chewing), Parkins	g at the table looked at NA-G [R51] to take smaller bites." if and told him to take smaller NA-G moved away from R51 hate. R51 continued to eat out verbal cues. NA-G then the table to wash her hands. RN-A got up and went to the ble to assist R51's tablemate. ed to the table, she sat at the R51. At 8:58 a.m. RN-A the tablemate (R12) with her 8:45 a.m. until 8:58 a.m. R51 at independently, and was arge amounts of food with each R51 started coughing and his N-A suggested at that time that u "get a therapy referral for sitioning while eating."					
	R51 had been seen and low-grade tem exam revealed "cra and occasional exp	ote dated 5/12/15, indicated n that day because of a cough perature. The physician's ackles in right mid lung field piratory wheeze." The physiciar icated R51 had been					
	diagnosed with asp been prescribed Au milligrams (mg) twi	biration pneumonia, and had ugmentin (an antibiotic) 875 ice a day for 7 days, and a t for four days and as needed.					
	A nursing progress	note dated 5/23/15 read, "is					

If continuation sheet 20 of 51

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 20	2 830			
		elf after set up, is at the feeder n. Eats slowly, is on nectar				
	5/26/15, indicated I self-understood ho communicating sor but was able if pror usually be understo indicated R51 may messages but com R51 was identified interview for menta which indicated mil MDS further indicated	num Data Set (MDS) dated R51 usually made wever, had difficulty me words or finishing thoughts mpted and given time, to bod by others. The MDS miss some parts or intent of prehended most conversation by the MDS to have a brief al status (BIMS) score of 11 d cognitive impairment. The ted R51 required limited a from one staff member for				
	identified a history assessment indicat physician prescribe puree meets and v liquids, no added s nutritional assessm "Resident has ha [due to] an occurre	sessment dated 6/19/15, of swallowing disorder. The ted the resident had a ed diet of mechanical soft with egetables with honey thick alt, no magic cups. The nent summary note included, d some changes to diet d/t nce [sic] of aspiration [2015]Resident is assisted a	t			
	therapy from 3/3 th signs and symptom according to the Sp	ed R51 had received speech rough 4/17/15, to decrease as of penetration/aspiration, beech Therapy Progress and are form dated 3/3/15.				
	written recommend	tes dated 3/19/15, included a lation to change R51's diet quids to honey thick liquids.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/	17/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 21	2 830		51)	
	additional recomm to mechanical soft meats, and honey recommendation ir at meals, make su scrambled." Speech therapy pre- indicated R51 utiliz	n therapy had made an endation to change R51's diet with pureed vegetables and thick liquids. The ncluded, "Supervision needed re eggs are pureed not ogress notes dated 4/17/15, red, "safe swallowing strategies with minimal verbal cues."				
	7/14/15, identified a difficulties related t pneumonia. The ca staff to provide a d meats and vegetab provide assistance allow. In addition th to sit at the 'assiste had not been revis	by the facility on a problem area of swallowing o dysphagia and aspiration are plan interventions directed iet of honey thick liquids, puree oles, no magic cups, and to at meals as the resident would be care plan indicated R51 was ded dining table'. The care plan ed to include the specific commendations identified on	t l			
	at 2:27 p.m. on 7/1 aware R51 was no	v with dietary assistant (DA)-A 4/15, DA-A stated she was not t supposed to have scrambled ave received eggs of a pureed d not.				
	p.m. she stated, "L two [identified R12 often that [R51]	with NA-K on 7/14/15 at 2:15 Isually every day there are just & R51] that cough, [R12] more R51 does good on his own I to sit by him when he eats."				
		v with NA-C on 7/14/15 at 2:15 R12 needs and should get				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/0015
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		077	17/2015
		525 BLU	FF AVENUE	TATE, ZIF CODE		
GOLDEN	I LIVINGCENTER - W	ST CHAF	RLES, MN 559	)72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 22	2 830			
	direct supervision- chin and swallow, H what is happening staff members to fe basically go back a aides in the dining management will h during the evening but they never are whole meal service R51 cough at ever NA-C explained R5 cueing then said, ' reference to cough During an interview NA-H was asked a during meals. She have coughing/cho NA-H stated the co because they both During an interview stated she normally verified there are u dining room. NA-I help if they were do stated most of the During an interview	he needs to be told to tuck his he holds food in his mouth, right now is there isn't enough eed 10 people so we have to and forth. There are only two room during meals, sometimes help during the day but not . A nurse might help pass trays in the dining room during the e." NA-C stated both R12 and y meal at least 3 to 4 times. 51 needed supervision and " He's not as bad as [R12] " in				
	room to assist all o assistance with eat assistants have to the two tables. NA- keep shoveling foo	Illy just two staff in the dining of the residents that need ting. NA-J stated the nursing move back and forth between -J also stated R12 "likes to od in his mouth" and takes big sually when food comes up.				
nnesota D	NA-J then explaine	ed prevention measures for to give verbal cues.				

STATEME	Dta Department of He NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	072		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	did not identify guid required changes t of residents who w aspiration. A policy precautions was re at 9:56 a.m. RD-A not have a policy. The immediate jeo was removed on 7, the facility had corr and R51 to rule dei had revised the res current speech the verified staff had bo the importance of s during meals, and resident specific im aspiration, and obs appropriate implem However, noncomp scope and severity and severity level, with potential for m the facility's popula swallowing difficulty SUGGESTED ME The director of nur- and revise policies implementation of have potential for a assessment, monit staff education rela The director of nur-	THOD OF CORRECTION: sing or designee, could review and procedures related to physician orders, and interventions for residents who				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		00942	B. WING			
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
OLDEN	I LIVINGCENTER - W	HIIEWAIEB	FF AVENUE RLES, MN 55	972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 24	2 830			
	TIME PERIOD FOI days.	R CORRECTION: Seven (7)				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			8/31/15
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	by: Based on interview facility failed to esta program that includ symptoms and type causal organisms a infections. In addition a soiled isolation lin overflowing in R22' appropriate clean to changing an indwe R12. The facility's	ent is not met as evidenced and document review, the ablish an infection control led consistent monitoring of of infection, tracking of and symptom resolution of on, the facility failed to ensure hen cart receptacle was not s room; and failed to ensure echnique was used when lling catheter collection bag for failure to establish an infection d the potential to affect all 45 ded in the facility.		Corrected.		
	Findings include:					
	LACK of INFECTIC	ON CONTROL PROGRAM:				
	sheet from 1/2015 flow sheet identified which was to be co coordinator: Room	of Resident Infections flow to 6/2015 was reviewed. The d the following information llected by the infection control , unit, resident name, be of infection, symptoms/date,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 25	21375			
		, other actions (if needed), and sociated Infection) or CAI red Infection).				
		ine Listing of Resident et revealed the following:				
	experienced possible twelve residents has (i.e. increased urina elevated temperatures residents had type twelve residents has the twelve resident	dents in the facility had ble infections. Eleven of the ad actual symptoms identified ary incontinence, cough, ure). Eleven of the twelve of infection identified. All ad antibiotic identified. None of s had causal organisms the twelve residents had n identified.	;			
	experienced possik residents had actua eight of the residen identified. All eight identified. One of t	ents in the facility had ble infections. Six of the eight al symptoms identified. All its had type of infection residents had antibiotic he eight residents had causal d. None of the eight residents lution identified.				
	experienced possible residents had actual the ten residents had All ten residents had the ten residents had	nts in the facility had ble infections. Six of the ten al symptoms identified. Nine of ad type of infection identified. Id antibiotic identified. None of ad causal organisms the ten residents had n identified.				
	experienced possible eleven residents have	idents in the facility had ble infections. Seven of the ad actual symptoms identified. sidents had type of infection				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	IFF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 26	21375			
	identified. None of causal organisms i	n residents had antibiotic the eleven residents had dentified. None of the eleven ptom resolution identified.				
	experienced possik eleven residents ha Ten of the eleven re identified. Nine of antibiotic identified. had causal organis	idents in the facility had ole infections. Nine of the ad actual symptoms identified. esidents had type of infection the eleven residents had . None of the eleven residents ms identified. None of the ad symptom resolution				
	Three residents in possible infections, had actual symptor residents had type residents had antib three residents had	ng of infections was provided. the facility had experienced Two of the three residents ns identified. Two of the three of infection identified. All three iotic identified. None of the d causal organisms identified. esidents had symptom d.				
	dated 4/6/15 includ program designed sanitary and comfo to help prevent the of disease or infect facilities." Although	, Infection Control Program led: "An infection control to provide and maintain a safe ortable work environment and development or transmission ion will be established for all n requested, there was no ded related to components of l program.	,			
	registered nurse-A responsible for the program. RN-A ve	n 7/15/15, at 1:30 p.m. (RN-A), stated she was facility's infection control rified the facility Line Listing of s was the facility's monitoring				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/	17/2015
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	072		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 27	21375			
	from 1/2015 to 6/20 monitoring of symp RN-A verified the ir identification of cau symptom resolution LACK of PROPER Isolation Linens: R22 was observed had isolation conta up-against the wall was ajar with soiled that had been sittin the container. NA-F cart outside of R22 room. When asked NA-F responded by infection control iss linens should have NA-F then stripped without putting glow container to open it container, and ther without washing he outside of the cove cover down over th hand sanitizer loca and came back in t NA-F completed th standard infection of During an interview stated R22 had VR Enterococcus) in a healed on her abdo VRE was in her ost call nurse practition	Handling and Storage of on 7/13/15, at 3:29 p.m. R22 iners in her room located . The lid of the linen container d linens touching two pillows og on top of chair adjacent to F had a covered clean linen d's room. NA-F came into the d about the overfull container, y explaining "that is an sue," she further explained the been removed from the room. I the pillow cases off the pillow yes on, touched the lid of the t, touched the linens inside the n walked outside of the room er hands and touched the er of the linen. NA-F used the ted outside the resident's room the room and put gloves on. the removal of the linens using				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/	17/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		17/2010
		525 BLU	FF AVENUE			
OLDEN	LIVINGCENTER - W	HITEWATER ST CHAP	RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21375	Continued From pa	age 28	21375			
	touching the linen of NA should have the washed her hands	dling the pillow cases and on the inside of the container, en taken off her gloves and prior to leaving the room.				
	protective equipme the guidelines direc use gloves.	d guidelines for personal ent for isolation circumstances, cted staff to wash hands and				
		and transportation of soiled requested and not received.				
	on 7/14/15, at 1:02 toilet, nursing assis catheter collection was going to chang cap from the new u and draped the new lift that had been in remove a connection catheter. After the used an alcohol wint touched the floor w soiled gloves touch	tion of activities of daily living p.m. R12 was sitting on the stant (NA)-C explained urinary bag had a hole in it and she ge it. NA-C removed the end urinary collection bag tubing w tubing over the mechanical in the bathroom, struggled to on piece on the actual Foley piece had been removed, NA- pe to clean the end, NA-C ther <i>i</i> th her right hand and with ned R12's clothing. NA-C did oves or wash/sanitize her				
	hands. NA-C proce tubing of the collect to connect the cont bag. NA-C was sto new sterile tubing v collection bag was R12's quarterly Mir 5/26/15 indicated n with a Brief Intervie	eeded to pick up the end of the tion bag. NA-C then was going taminated end of the collection pped by surveyor before the was connected, and a new				
asota D	had an indwelling F					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00942	B. WING		07/	17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	HITEWATER	IFF AVENUE RLES, MN 559	72			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 29	21375				
	should have taken and donned new g and the resident's tubing should not h mechanical lift. The facility provide Insertion and Rem was last reviewed	(DON) explained the NA off gloves and washed hands loves after touching the floor clothes and the collection bag have been draped over the d policy Catheter (Indwelling) oval of (Female and Male) that 1/26/15, the policy did not in changing urine collection	t				
	The Director of nur follow and impleme	THOD OF CORRECTION: rsing could in-service staff to ent a sound infection control pnitor for compliance.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	e				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			8/26/15	
	maintain a compre- infection control pr- current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provid	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines.					
	(b) Written compli	ance with this subdivision mus	+				

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00942	B. WING	·····	07/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WI	HITEWATER	FF AVENUE LES, MN 55	972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 30	21426			
	be maintained by th	e nursing home.				
	by: Based on interview facility failed to ensure received two-step to failed to ensure 1 of two-step tuberculos to ensure a tuberculos to ensure a tuberculos to ensure a tuberculos to ensure a fuberculos facility, staff and vis Findings include: EMPLOYEE SKIN EE had a hire date	TEST: of 2/16/15, according to new		Corrected.		
	facility tuberculosis 2/16/15, revealed E risk factors, and syn	ter. Document review of (TB) screening tool dated -5 was screened for history, mptoms of tuberculosis on entified EE received first step				
	read on 2/19/15, wi induration. The sec	on 2/16/15. The skin test was th results 0 millimeters cond step skin test was 2/15 or more than three				
	read on 6/4/15, with induration.	st TST. The skin test was results 0 millimeters				
	Exposure Control P following:	f facility Tuberculosis lan dated 1/6/15, revealed the				
		for skin testing for new				
		w hires- "All new admissions, nd volunteers as defined				
Alexander D	above will receive a	2-step Mantouxunless they				
unnesota D	epartment of Health					

If continuation sheet 31 of 51

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	I LIVINGCENTER - W	HITEWATER	FF AVENUE			
		SI CHA	RLES, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 31	21426			
	Step 1, if Step 1 is During interview on registered nurse (F her expectations w was administered w 48-72 hours, and s administered sever results were read. receive the second facility policy. RN-/ the the skin test ha months after the fir RESIDENT SKIN T R60 was admitted f according to facility Infections for 1/201 baseline TB screen 12/4/14, revealed risk factors, and sy 12/4/14. Documen screening tool for r revealed no docum the skin test had be evidence of indurat documented evider second step skin test Document review of for R60, revealed to on 12/4/14. There date results of the s documented evider and no documenter the second step skin test page 11-Guidelines	e administered 7-10 days after negative." 7/15/15, at 1:30 p.m., RN)-A stated facility policy and ere that the first step skin test when hired, results read within econd step skin test n days after the first step RN-A verified E-5 did not step skin test according to A stated she did not know why d been administered 3 plus st test. TEST: to the facility on 12/3/14, r Line Listing of Resident 5. Document review of facility ning tool for residents dated R60 was screened for history, mptoms of tuberculosis on t review of facility baseline TB esidents dated 12/4/14, tented evidence date results of een read, no documented ion of skin test, and no nce of administering the est. of facility immunization record uberculin skin test was given was no documented evidence skin test had been read, no nce of induration of skin test, d evidence of administering				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FFAVENUE	972		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET
21426	Continued From pa	age 32	21426			
	above will receive a have a documente "Step 1-to b admission/or on hin "Step 2-to b Step 1, if Step 1 is During interview or verified R60 lacket test and lacked evi skin test. RN-A state expectations were were read within 48 skin test administe step results were re receive the second facility policy. STAFF TRAINING Document review of Exposure Control F following: Page 3-Oversight F and training." Page 4-In-Service requiring the perfor appropriately identia associate before in assignment." Page 7-Administrate "educating and trai Although requested tuberculosis trainin SUGGESTED MET The director of nur policies and proced	e administered on re," e administered 7-10 days after negative." n 7/15/15, at 1:30 p.m., RN-A d results of the first step skin dence of received second step ted facility policy and her the first step skin test results 3-72 hours, and second step red seven days after the first ead. RN-A verified R60 did not I step skin test according to of facility Tuberculosis Plan dated 1/6/15, revealed the Function included "education of Associates "Job positions mance of such tasks are ified and explained to each itial patient/resident tive Measures included ning applicable persons." d, no evidence of staff				
	staff to their policie employee and resid	s and procedures for dent tuberculosis skin tests. sing could provide all staff				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	F AVENUE LES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ao 22	21426	DEFICIENCY	)	
21420	ongoing tuberculos	is training. The director of tor staff compliance.	21420			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	0 A.B.C Drug Regimen Review	21530			8/31/15
	currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or su pharmacist. For pu upon" means the at report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician. If the me the attending physic	nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan abject to frequent change. director of nursing services shysician, and these reports n by the time of the next ooner, if indicated by the arposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ing physician does not concur t's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/17/2015	
		00942	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 55	5972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 34	21530			
	must be referred for assessment and as by part 4658.0070. the medical director must refer the mat assessment and as This MN Requirem by: Based on observat review the facility for pharmacist identified non-pharmacologic administration of as for behavioral outb R41 & R22) review	change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee. The tis not met as evidenced tion, interview and document ailed to ensure the consultant ed lack of irregularities for cal interventions utilized prior to s needed (PRN) medications ursts for 3 of 5 residents (R8, yed for unnecessary		Corrected.		
	medications. Findings include:					
	R8's most recent p and dated 7/7/15, r the following psych (anxiety medication pulse areas topical	hysician order sheets signed revealed that R8 had orders for noactive medications: Ativan n) 0.5 milligrams (mg), apply to lly every 4 hours as needed fo oly Ativan gel to pulse areas.				
	On 7/3/15, Ativan ( topically for anxiety behavior. On 5/14/15; 5/23/2 behavior) Ativan 0. topically for anxiety documentation on administered topica	Aministration Record revealed: 0.5 mg was administered 7. No documentation of 5 mg was administered 7, and on 5/29/15, no behavior that day, Ativan 0.5 mg was ally for anxiety.				

STATE FORM

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If continuation sheet 35 of 51

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 35	21530			
		havior documentation on that y was administered topically for	r			
	medication administ non-pharmacologic attempted by staff	vas no documentation on the stration record (MAR) that cal interventions were prior to administering the of 6 doses administered.				
	8/3/14-7/12/15 and indicate that non-p	were reviewed from I revealed no documentation to harmacological interventions or to the administration of R8's				
	R8 for the past yea no direction provide	sing assistant care sheets for a also revealed there had beer ed for the nursing assistants to nalogical interventions for R8's				
	and dated 7-9-17 ( revealed that R41   psychotropic medic (antianxiety medica topically as needed Supplied in 1 mg/m Apply 0.5 ml topica	physician order sheets signed error-was to be 7/9/15) had orders for the following cations: Ativan Solution ation), Apply to pulse regions d for anxiousness and agitation h individual syringe dose. Illy to pulse points as needed. derm if the resident is rubbing	,			
	Review of R41's M Record (MAR) reve a. On 4/3/15 - Ativa was administered f b. On 5/15/15; 5/24	an Solution 0.5 milliliters (ml) for anxiety and 4/15; Ativan Solution 0.5 ml for anxiety. There was no				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/17/2015	
		00942	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	172		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE	(X5) COMPLET DATE
TAG			TAG	DEFICIENC		5/112
21530	Continued From pa	age 36	21530			
		cal interventions were prior to administering the R41.				
	5/24/15 and reveal indicate that non-pl	s were reviewed from 4/3/15 to ed no documentation to harmacological interventions or to the administration of c medication.				
	non-pharmacologic attempted prior to a medications. The E should be documen behavior charting. no documentation	p.m. the DON stated cal interventions should be administration of the PRN DON stated the interventions nted in the progress notes or The DON confirmed there was of non- pharmacological 3/15, 5/15/15, or 5/24/15 for				
	pharmacist (CP)-A attempted non-pha	p.m. the consultant stated documentation of irmacological interventions ed in residents' medical record medications.	1			
	spoken to his supe non-pharmacologic PRN medications v pharmacy review.	a.m. CP-A stated he had prvisor and monitoring for cal interventions prior to using was not part of the monthly				
	commencing on Au Scope of Services. medication regime Facility Patient at le	acist Services Agreement ugust 26, 2014 read, "1. 1.2 perform a comprehensive n review ("MRR") of each east once a month and report ularities, deviations, or unusual				
ppopoto D	occurrences to Fac Medical director, D	cility's Executive Director, irector of Nursing and/or, to the Patient's attending				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID		ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 37	21530			
	Facility Patient at le	ew the drug regimen of each east once a month and report ularities, deviations or unusual				
	according to the fa diagnoses that incl rheumatoid arthritis regions, malignant perforation of intes weakness, patholo obesity, and chron R22's quarterly Mir 6/30/15 indicated r Brief Interview for I 15 and required ex complete activities further indicated th pain medication ar medication. R22's care plan pre- informed staff of the related to: osteopo The care plan direct mediation as order could serve to distr routinely scheduled pain medication act to provide medicat therapy, implemen non-pharmacologic repositioning, move R22's physician or	to the facility on 12/29/14 cility admission record with uded but was not limited to s, abscess of anal and rectal neoplasm intestinal tract, tine, osteoporosis, muscle gical fracture of a vertebrae, ic pain. himum Data Set (MDS) dated to cognitive impairment with a Mental Score (BIMS) score of tensive assist from staff to of daily living. The MDS e resident received scheduled ad utilized as needed pain by ided by the facility on 7/14/15 the need for pain management rosis and rheumatoid arthritis. cted staff to administer pain red, identify items/activities that ract pain, evaluate the need for d medications rather than PRN liministration, evaluate the need cal pain relief strategies (rest, ement to a quiet environment) ders provided by the facility on he following PRN (as needed)				
	mouth every six horestlessness, and	ylenol 650 milligrams (mg) by burs as needed for pain and Dilaudid 2 mg by mouth every for pain between 2:00 p.m.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	017	17/2013
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE	-		
0(0) 15			RLES, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 38	21530			
	were reviewed from 2015. The June MAR ind PRN Tylenol three used in combinatio records indicated th prior to the PRN Di indicated the Tylen after 6/7/15. The M had been administe June; 53 doses we dosing of Tylenol o was not evident in offered for R22 prio Dilaudid. It was als record non-pharma attempted prior to a any of the doses ac July's MAR indicate and PRN Dilaudid was not evident in non-pharmacologic attempted prior to to Dilaudid for any of R22's nursing prog for June and July, t notes simply indicat that was administe using a 0-10 pain s was "effective" or " notes lacked a pair would include locat description of the p During an interview director of nursing documentation of r intervention prior to pain medication. The	ed no use of the PRN Tylenol was administered 13 times. It the medical record cal interventions were the administration of PRN the doses administered. ress notes were also reviewed the majority of the progress ated the PRN pain medication red, the intensity of the pain scale, if the pain medication ineffective." The progress in assessment/evaluation that tion and characteristics or				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00942	B. WING		07/	/17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ge 39	21530			
	non-pharmacologic outcome. The facility's policy Medication Manage 2011, did not reflec non-pharmacologic PRN medications. SUGGESTED MET The Director of nur responsible for med consultant pharmacologic	ould include the use of cal interventions and the Medication Monitoring and ement, last revised November t current standards for use of cal interventions prior to use of THOD OF CORRECTION: sing could in-service all staff dication monitoring including cist on the need to use cal interventions before use of cation use. Monitoring for to be done also.				
21535	(21) days.	R CORRECTION: Twenty-one	21535			8/31/15
	Drug Usage; Gener Subpart 1. Genera must be free from u unnecessary drug i A. in excessive therapy; B. for excessiv C. without adea D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in	ral al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/17/2015	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W	HITEWATER	IFF AVENUE RLES, MN 55	5972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 40	21535			
	Department of Hea Health Care Finand This standard is in available through t	acilities, published by the alth and Human Services, cing Administration, April 1992 corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on observat review, the facility document non-pha to using as needed behavioral outburs	tion, interview and document failed to implement and irmalogical interventions prior d (PRN) medications for ts or pain, for 3 of 5 residents o reviewed for unnecessary		Corrected.		
	Findings include:					
	and dated 7/7/15, it the following psych (anxiety medication pulse areas topical	hysician order sheets signed revealed that R8 had orders fo noactive medications: Ativan n) 0.5 milligrams (mg), apply to ly every 4 hours as needed fo ly Ativan gel to pulse areas.	)			
	On 7/3/15, Ativan ( topically for anxiety behavior. On 5/14/15; 5/23/2	dministration Record revealed: 0.5 mg was administered 7. No documentation of 5 (no documentation of				
	behavior) Ativan 0. topically for anxiety documentation on administered topic. On 4/15/15, (no be	5 mg was administered /, and on 5/29/15, no behavior that day, Ativan 0.5 mg was				

STATE FORM

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 41	21535			
		On 1/10/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.				
	In addition, there was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.					
	8/3/14-7/12/15 and indicate that non-pl	were reviewed from revealed no documentation to harmacological interventions or to the administration of R8's				
	R8 for the past yea no direction provide	sing assistant care sheets for Ir also revealed there had been ed for the nursing assistants to alogical interventions for R8's				
	and dated 7-9-17 R41 had orders for medications: Ativar medication), Apply needed for anxious in 1 mg/ml individu topically to pulse po	physician order sheets signed (error in date) revealed that the following psychoactive n Solution (antianxiety to pulse regions topically as sness and agitation, Supplied al syringe dose. Apply 0.5 ml pints as needed. Cover with a sident is rubbing the				
	revealed: a. On 4/3/15 - Ativa was administered f b. On 5/15/15; 5/24 was administered f	administration Records an Solution 0.5 milliliters (ml) or anxiety and I/15; Ativan Solution 0.5 ml or anxiety. There was no the medication administration				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00942	B. WING		07/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	)72		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 42	21535			
	interventions were	non-pharmacological attempted by staff prior to Ativan Solution for R41.				
	5/24/15 and reveal indicate that non-p	s were reviewed from 4/3/15 to ed no documentation to harmacological interventions or to the administration of e medication.	)			
	non-pharmacologic attempted prior to a medications. The E should be docume behavior charting. no documentation interventions on 4/3	p.m. the DON stated cal interventions should be administration of the PRN DON stated the interventions nted in the progress notes or The DON confirmed there was of non-pharmacological 3/15, 5/15/15, or 5/24/15 eceived PRN ativan).				
	according to the fa diagnoses that incl rheumatoid arthritis regions, malignant perforation of intes weakness, patholo obesity, and chroni R22's quarterly Mir 6/30/15 indicated n Brief Interview for N 15 and required ex complete activities further indicated th pain medication an medication. R22's care plan pro	himum Data Set (MDS) dated to cognitive impairment with a Mental Score (BIMS) score of tensive assist from staff to of daily living. The MDS e resident received scheduled ad utilized as needed pain by ided by the facility on 7/14/15				
	informed staff of th related to: osteopo	e need for pain management rosis and rheumatoid arthritis. cted staff to administer pain				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		00942	B. WING		<b>07</b> /	07/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	N LIVINGCENTER - W	HIIEWAIER	FF AVENUE RLES, MN 559	72			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
21535	Continued From pa	age 43	21535				
	could serve to distr routinely scheduled pain medication ad to provide medicati therapy, implement non-pharmacologic repositioning, move R22's physician ord 7/15/15 included th pain medication: Ty mouth every six ho restlessness, and I 2 hours as needed and 2:00 a.m. R22's medication a were reviewed from 2015. The June MAR indi PRN Tylenol three used in combinatio records indicated th prior to the PRN Di indicated the Tylend after 6/7/15. The M had been administe June; 53 doses we dosing of Tylenol o was not evident in to offered for R22 prio Dilaudid. It was als record non-pharma attempted prior to a any of the doses ad July's MAR indicate and PRN Dilaudid w was not evident in to non-pharmacologic	ed no use of the PRN Tylenol was administered 13 times. It					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
AME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 44	21535			
	for June and July, f notes simply indicat that was administe using a 0-10 pain s was "effective" or " notes lacked a pain would include locat description of the p During an interview director of nursing documentation of r intervention prior to pain medication. T was that staff would evaluation which w non-pharmacologic outcome. The facility's policy Medication Manage 2011, did not reflect non-pharmacologic PRN medications. SUGGESTED MET The Director of nur staff responsible for related to the need non-pharmacologic medications when include the importation interventions in met their facility medicat a system to monitor	v on 7/16/15 at 11:18 a.m., the (DON) verified the absence of non-pharmacological o the administration of PRN he DON stated her expectation d fully document a pain rould include the use of cal interventions and the "Medication Monitoring and ement, last revised November et current standards for use of cal interventions prior to use of CAL INTERVENTION: rsing could provide training for or medication administration to include cal interventions in lieu of possible. The facility could ance of non-pharmacological peting the needs of residents in ation policies and could develop				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00942	B. WING		07/17/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 55	5972	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
21565	Continued From pa	age 45	21565		
21565	MN Rule 4658.132 Medications Self A	5 Subp. 4 Administration of dmin	21565		8/31/15
	self-administer med resident assessme care as required in 4658.0405 indicate is a written order fro This MN Requirem by: Based on observat review, the facility f assessment to dete capable to self adm resident (R8) review	ninistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician. ent is not met as evidenced ion, interview and document failed to conduct an ermine whether a resident was ninister medications for 1 of 1 wed for self administration of		Corrected.	
	medication. Findings Include:				
	assessment dated as having moderate daily decision maki indicated the reside anxiety state. Curre on the July 2015 M Record, included u	mum Data Set (MDS) 6/9/15, identified the resident ely impaired cognitive skills for ng. In addition, the MDS ent's diagnoses included ent physician's orders identified edication Administration se of Miralax Powder instipation), give 1 scoop by ng for constipation.			
	was observed to be activity director (AE (RN)-B. Licensed p stopped the supper was for R8. LPN-A from R8's supper to	p.m. a cart with supper trays e taken from the kitchen by the D)-A and registered nurse oractical nurse (LPN)-A r tray cart and asked which tra removed the chocolate milk ray and poured powdered medication cup into the			

STATE FORM

4HCK11

If continuation sheet 46 of 51

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00942	B. WING		07/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W	HITEWATER	FF AVENUE RLES, MN 559	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	Miralax into R8's cl the chocolate milk tray back into the c the medication car medications for oth continued towards R8 her supper tray RN-B was heard to you watch her? Sh RN-B returned at 7 drink her chocolate At 7:14 p.m. RN-B surveyor about wha assessed to self ac medication. R8 ste immediately return self administer." W been an assessme administer the med know, but I'll just ta	was questioned by the ether or not R8 had been dminister the Miralax pped away for a moment and ed stating, "she has an order to then asked whether there had ent of R8's ability to self dication, RN-B stated, "I don't ike it away so you don't have to was then observed to take the				
	On 7/13/15 at 7:30 was routine practic chocolate milk and whomever is delive will not drink it if I b way. She just gets her." When LPN-A been assessed to a she stated, "I don't creative to get her On 7/13/15 at 7:38	p.m. LPN-A was asked if it e to place Mirilax in R8's send the tray to her room with ering trays. "With her it is. She oring it in. We have to do it that agitated when people watch was asked whether R8 had self administer medications know, we just have to get				
	ability to self admin	hister medications. RN-A also d not be normal practice to				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED		
		00942	B. WING		07/	17/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	LIVINGCENTER - W	HITEWATER	UFF AVENUE ARLES, MN 559	72			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21565	Continued From pa	age 47	21565				
	place medication ir and send with the r	nto a resident's chocolate milk meal tray.					
	completed for R8 of Resident/patient re medications: 'No. N The Interdisciplinar was 5/19/14, and w review. The note in The facility's policy Adminstation-Gene dated 5/12 included person who prepar is the person who a Residents are allow medications when	eral Guidelines, Section 7.2 d: "B. Administration 5. The es the dose for administration administers the dose. 13. ved to self-administer specifically authorized by the and in accordance with	1				
	The facility could re administration, poli education to staff, t assessments are c residents to self ad facility could also d	THOD OF CORRECTION: eview their medication, self cy and procedure, provide they could ensure completed prior to allowing lminister medications, the evelop and audit tool and ongoing compliance.					
	TIME PERIOD FO (14) days.	R CORRECTION: Fourteen					
21665	MN Rule 4658.140	0 Physical Environment	21665			8/31/15	
		ust provide a safe, clean, able, and homelike physical ing the resident to use					

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00942	B. WING		07/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	HITEWATER	FF AVENUE LES, MN 55	972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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
21665	Continued From pa	ige 48	21665			
	personal belonging	s to the extent possible.				
	by: Based on observative view, the facility for maintained in proper This had the potent residing in the facility is sheets. Findings included: On 7/7/15, at 9:00 a observed parked in Hanging on top of the which was observed brown, white and go mesh cloth attached was observed to be	ent is not met as evidenced ion, interview and document ailed to ensure lift sheets were er repair and were kept clean. tial to affect 11 of 11 residents ty who utilized the shared lift a.m. a transfer lift was the hallway on the 100 Wing. he lift was a blue lift sheet d to be soiled with multiple reen stains. In addition the d underneath the the lift sheet, e torn off and the ripped mesh		Corrected.		
	machine was obser of the 300 Wing. The to be soiled with browsheet. On 7/16/15, at 12:3 the environmental to manager (MM) he was the Sit to Stand lifts what the brown, who were MM was not a when they were direct clean them. When were cleaned MM so further stated the fat	a.m. another transfer lift rved stationed in mid-hallway he blue lift sheet was observed own and white spots on the lift 0 p.m. to 12:47 p.m. during our with the maintenance verified both the lift sheets for swere not clean. When asked ite and green spots/marks able to indicated and stated ty laundry department would asked how often the lift sheets stated he was not sure. MM acility currently had two Sit to as one had gone down				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00942	B. WING		07/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	I LIVINGCENTER - W	HITEWATER	F AVENUE			
		SI CHAR	LES, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	ige 49	21665			
	recently.					
	(DON) verified the l transfers lift in the 1 with ill repair. When was of staff DON si- send the lift sheets they noticed it was stated she would have report to her the lift indicated she had to not sure if the lift sh further stated the lift residents in the fac On 7/16/15, at 1:55 surveyor and stated sheets were cleaned sent down to laund On 7/16/15, at 5:11 approached the sur- residents that share	<ul> <li>p.m. the MM approached the d he had found out the lift ed as needed and would be ry when dirty.</li> <li>p.m. registered nurse (RN)-A rveyor to provide names of ed the Sit to Stand transfer lift</li> </ul>				
	was a cleaning sch sheets were cleane schedule and state supposed to be cle acknowledged the needed to be kept of to room.	When asked whether there edule for when the shared lift ed, RN-A stated there was no d the lift sheets were aned when dirty. RN-A lift sheets were shared and clean as they went from room				
	was observed static Wing outside room was hanging on top observed to be soil	p.m. a Sit to Stand transfer lift oned by the fire door in the 100 104 and the lift sheet which o of the machine was still ed even though the concern o the facility's attention.				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00942	B. WING		07/	17/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	LIVINGCENTER - W	/HIIEW/AIER	FF AVENUE RLES, MN 559	72			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From pa	age 50	21665				
	The director of nur- educate staff regar- clean, functional ar DON or designee, maintenance and h periodic audits of a ensure a safe, clear environment is main	THOD OF CORRECTION: sing (DON) or designee, could rding the importance of a safe, nd homelike environment. The could coordinate with nousekeeping staff to conduct areas residents frequent to an, functional and homelike intained to the extent possible. R CORRECTION: Seven (7)					
	epartment of Health						