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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4XOS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/29/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Carol Bode, HFE NE II 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 03/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 03/11/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1089
February 10, 2015

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

RE: Project Number S5298026

Dear Mr. Gershone:

On January 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 10, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 10, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 29, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 29, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Golden Living Center Twin Rivers objects to the allegations of non-compliance in this Statement of Deficiency Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission against interest of the facility, the administrator of any employees, agents or other individuals who draft or may be discussed in this Response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, GLC Twin Rivers has prepared and submitted this Plan of Correction solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten days of the survey as a Condition of Participation in Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the facility.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164		

3/2/15 AA accepted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Oestreich
TITLE: Executive Director
(X6) DATE: 2/20/2015

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.

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures to ensure personal privacy during care for 1 of 6 residents (R51) who were dependent upon staff for personal cares. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 11/11/2014, identified intact cognition, and further that R51 had a physical functioning deficit, related to self-care and mobility impairments. The MDS further identified R51 required extensive assistance with bed mobility and dressing. During continuous observation on 1/28/2015 at 9:27 a.m. until 10:00 a.m. (33 minutes), R51's door was fully open, and the room slightly darkened, with the outside window drapes closed. R51 was lying atop the bed, only wearing only an incontinent brief. A privacy curtain, immediately to the right of R51's bed, was not pulled exposing R51 from head to to toe, to anyone passing by the room. During this time, numerous facility staff passed by R51's door, including unidentified nurses, nursing assistants, maintenance personnel, housekeeping and dietary workers. No one made any attempts to close the door or privacy curtain to provide privacy for R51. Additionally, two unidentified residents pushed	F 164	F 164 It is the Policy of Golden Living Center Twin Rivers that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. To assure continued compliance the following plan has been implemented. Resident # 51 insists on keeping his door and privacy curtains open due to his agitation when in an enclosed area. He will not keep a shirt on, preferring to lie in a brief only. Staff efforts to provide privacy by covering the resident, closing the curtain or closing the door create agitation and verbalized panic from the resident. To correct this situation the following plan is in place: • Review results from upcoming psychiatric evaluation for R51 and tailor behavioral approach to these findings. • Establish with the resident that he must wear a shirt and cover his lower extremities with pants or his blanket. Include in the plan that if he takes off the shirt, his privacy curtain will be pulled. We will care plan this approach and pursue it consistently every day. • Educate staff on the standard for individual respect and dignity and what will be done to ensure R 51 is provided the opportunity for personal privacy at all times. • The DNS or designee will conduct weekly audits to assure continued compliance until we establish a consistent outcome that he is wearing a shirt and is otherwise	

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F 164	Continued From page 2 their wheel chairs past R51's room. One resident with a four-wheeled walker, a second walking independently, and still another resident, who was assisted by two unidentified staff, all ambulated past R51's open room door. At 9:43 a.m., a visitor and two young children walked past R51's door, and entered the next room down the hallway. R51 continued to remain on top of his bed during this time with only his brief on. R51 door and privacy curtain was not closed exposing R51 to other residents, staff and visitors who walked by his room. During an interview on 1/28/2014 at 1:58 p.m., nursing assistant (NA)-H stated she observed "[R51] not appropriately clothed this morning." NA-H said "we do struggle with that resident" in keeping the drape closed, and [R51] covered, and that "it happens frequently." NA-H stated it was "offensive to me" and not appropriate" that others have to see [R51] unclothed." In an interview on 1/29/2014 at 9:17 a.m., licensed practical nurse (LPN)-B stated "We have talked with [R51] frequently and have tried to convince him to keep the drape closed. [R51] does not like to put clothes on." LPN-B further said "It is not right and we have to be mindful especially of visitors that come into the building." LPN-B said "[R51] should be covered." During an interview on 1/28/2014 at 9:27 a.m., the director of nursing (DON) stated she agreed there was a concern of privacy for R51. "I'm right with you with that," the DON said. The DON further said the staff was very aware of the situation, and were having a difficult time either keeping [R51] "covered up, with at least a T-shirt" or encouraging him "to keep his drape closed."	F 164	covered so his privacy and dignity are ensured. • Subsequent resident admissions to Twin Rivers who may exhibit similar behaviors will be approached in a similar manner. We will continue to try various approaches until we have a successful means of achieving the goal of having the resident's privacy and dignity ensured. The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance F241 It is the Policy of Golden Living Center Twin Rivers that each resident receives care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	

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F 164	Continued From page 3 A facility policy regarding resident privacy was requested, but none was provided.	F 164	Plan for corrective action: • For each resident identified in the survey report; Residents 48, 73 and 34; an interdisciplinary care conference will be completed to review the resident's options and preferences to ensure the facility provides care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Family members will be included as much as possible to determine the best plan to meet the needs of the resident. The plan will be documented on the care plan and staff educated to it's specifics. • When assessing the needs of new residents, those who have upcoming care conferences or those who may have had a change in condition, the IDT will offer a range of options for bathing, grooming, eating and other key ADLs that will ensure the resident's expressed needs are met. For new residents, the completion of initial admission paperwork and the 48-hour meeting will focus on identifying the preferences of the resident and how to implement them.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was provided for 3 of 6 residents (R48, R73 and R34) in the sample who were dependent on staff for activities of daily living. Findings include: R48's admission minimum data set (MDS) dated 12/3/14 identified R48 was cognitively intact and needed extensive assistance with activities of daily living. During interview on 1/26/15, at 7:35 p.m. R48 stated she frequently has to wait long periods for staff to help her use the bathroom, and has suffered episodes of incontinence [involuntary loss of urine] because she waits so long, "Then I am miserable, I can't hold myself." She had spoken with staff before about her concerns. R73's admission MDS dated 12/09/14, indicated he was cognitively impaired and was dependent upon staff for activities of daily living. During interview on 1/27/15, at 9:27 a.m. family member	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 4 (FM)-K stated R73 often comments to him that staff take long periods, up to an hour at times, to provide care and often say they will "be right back," however then not return to help him. R73 has requested a shower, but the facility only gives him a bed bath so FM-L comes in and completes a shower for him. R34's quarterly Minimum Data Set (MDS), dated 10/12/15, identified R34 had moderate cognitive impairment, required extensive assistance for all activities of daily living (ADL)'s, and has an indwelling urinary catheter. During observation on 01/27/15, at 2:32 p.m. R34 was lying on top of his bed, his clothes and shoes were on, his indwelling urinary catheter tubing was coming out the bottom of his pants. The indwelling urinary catheter bag was lying on the floor with urine in it. The bag was not concealed with any covering, identifying to other residents and visitors that R34 had a urinary catheter. During interview on 01/28/2015, at 7:08 a.m. licensed practical nurse (LPN)-A agreed that the indwelling urinary catheter bag should be covered. LPN-A placed the urinary bag in a protective black bag, stating "it shouldn't be like that." An interview on 01/28/2015, at 7:47 a.m. registered nurse (RN)-A stated the black bag is called a privacy bag and the urinary catheter bag should be in the black bag.	F 241	• All staff to be educated on the meaning of F241 and the importance of delivering the care outlined on the care plan. This education will include instruction on how to listen to the resident and pick up on any new or different preferences that my emerge. • The DNS or designee will conduct weekly audits to assure compliance with care plans of the residents identified in the survey report to ensure their preferences and individuality are incorporated into the plan. Weekly audits will also be done randomly on other residents in the facility to ensure we are following the care plan. The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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F 242	Continued From page 5 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor bathing preference for 2 of 3 residents (R17, R73) reviewed for bathing choices. Findings include: R17's annual Minimum Data Set (MDS), dated 1/30/14, identified it was "very important" for her to have a choice in her bathing and bed time. R17's most recent quarterly MDS, dated 10/30/14, identified she had moderate cognitive impairment, and require physical assistance for bathing and activities of daily living (ADL). During interview on 1/26/15, at 3:19 p.m. R17 stated she was currently being bathed in the evening, but would rather be bathed in the morning hours so she would not have to get undressed again, "Its a nuisance." Further, R17 had told staff of this request in the past but nothing changes. An undated facility LTC (long term care) Bath Schedule, identified R17 was receiving a weekly bath on Saturday evenings. When interviewed on 1/28/15, at 12:49 p.m.	F 242	F242 It is the Policy of Golden Living Center Twin Rivers that each resident has the right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care, interact with member of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident. Plan of correction for two residents for whom the survey noted that the facility failed to honor bathing preference. Plan for corrective action: • For each resident identified in the survey report; Residents 17 and 73, an interdisciplinary care conference will be completed to review the resident's bathing options and preferences to ensure the facility meets those preferences. Family members will be included as much as possible to determine the best plan to meet the needs of the resident. The plan will be documented on the care plan and staff educated to it's specifics.	

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F 242	Continued From page 6 nursing assistant (NA)-A stated she frequently helps R17 with her evening baths, and R17 frequently voiced she did not like them because of having to get undressed. Further, NA-A stated a resident's choices for bathing should be honored, "I do think its important." During interview on 1/28/15, at 1:24 p.m. licensed practical nurse (LPN)-B stated R17 was scheduled to receive an evening bath, however she was unaware she voiced a dislike for her evening bath, "I didn't know that." Further, LPN-B stated a resident should be able to choose when they are bathed, "Its important they get what they want." When interviewed on 1/29/15, at 9:23 a.m., the director of nursing (DON) stated resident choices for bathing should be honored. R73's admission Minimum Data Set (MDS) dated 12/09/14, indicated he was cognitively impaired and it was very important for him to have a choice between tub bath, shower, bed bath or sponge bath. The MDS further identified he needed extensive assist with bathing and activities of daily living. R73's care plan dated 12/03/14, indicated he needed assist of one with his personal hygiene but did not address R73's bathing preference. During interview 1/29/15, family member (FM)-A stated R73 used to take a shower at least every other day. They discussed this with the staff at the facility that R73 would like at least a few showers a week. FM-A further stated the facility is not giving R73 a shower so FM-B comes in weekly to give R73 a shower.	F 242	• When assessing the needs of new residents, those who have upcoming care conferences or those who may have had a change in condition, the IDT will offer a range of options for bathing and other key ADLs that will ensure the resident's expressed needs are met. For new residents, the completion of initial admission paperwork and the 48-hour meeting will focus on identifying the preferences of the resident and how to implement them. • All staff to be educated on the meaning of F242 and the importance of following the bathing plan. This education will	

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F 242	Continued From page 7 During interview 1/29/15, at 12:52 p.m. FM-B stated she comes to the facility two to three times a week and gives R73 a shower. R73 is alert but has physical difficulties. FM-B stated on 1/26/15, in the evening she had visited R73 and staff had just finished giving him a bed bath. FM-B stated "I wish they would give him a shower I don't know why they won't do that for him." This is what he likes. Review of the facility Resident Bathing Type Weekly Report from 12/02/14 thru 1/27/14 indicated R73 received one shower in nine weeks and refused three times. The report did not indicate why he had refused. During interview 1/29/15, at 9:06 p.m. with (NA)-E stated she only works with R73 in the evenings and R73 bath schedule is Monday evenings. During interview 1/29/15, at 9:31 p.m. RN-A stated she was not aware that R73 would like more than one shower a week and staff were not providing R73 with a shower. RN-A stated she did not know why he had refused three times. During interview 1/29/15, at 1:03 p.m. with the facility administrator and director of nursing (DON) both stated choices were important for the residents. The administrator stated they could add on the facility care conference form to ask the resident specifically what there bathing preference was. They would place the resident's preference on the nursing assistance sheets so they were aware of their bathing preference. The DON stated they will make sure he receives his shower according to his preferences. A facility Bath, Partial policy, dated 1/26/15,	F 242	include instruction on how to listen to the resident and pick up on any new or different preferences that my emerge. • The DNS or designee will conduct weekly audits to assure compliance with care plans of the residents identified in the survey report to ensure their choices for bathing are incorporated. Weekly audits will also be done randomly on other residents in the facility to ensure we are following the care plan. The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance.	

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F 242	Continued From page 8 identified an assessment guideline of, "Resident's preference for time of day, frequency and type of bath", and further indicated a resident's preference for bathing should be care planned.	F 242	F282 It is the Policy of Golden Living Center Twin Rivers that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. The survey team observed the R17 was not transferred per the care plan. Plan for correction: • The current lift assessment for R17 will be reviewed and updated if needed to reflect current transfer assist needed. Ongoing lift assessments will be reviewed on a quarterly basis and when a change in level of care is noted. The care plan will be reviewed to ensure that the lift assessment is accurately noted. Education provided to NAR that was noted transferring resident during observation.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions for transfers were followed for 1 of 3 residents (R17) reviewed for activities of daily living. Findings include: R17's quarterly Minimum Data Set (MDS), dated 10/30/14, identified R17 had moderate cognitive impairment, was unsteady moving from a seated to standing position, and required extensive assistance for transfers and bed mobility. R17's Comprehensive Narrative Assessment, dated 11/5/14, identified R17 should be using, "Assist of two staff using stand lift with transfer in and out of bed." R17's care plan, dated 10/31/14, identified she was at risk for falls and provided an intervention of, "A2 [assist of 2] with stand up lift [a machine that helps someone stand] with transfers in and	F 282		

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F 282	Continued From page 9 out of bed." Review of the facility NA (nursing assistant) Group Sheet (a type of pocket care plan) identified R17 was to have two NA's and a mechanical stand lift to transfer R17 out of bed. During observation of morning care on 1/28/15, at 6:51 a.m. nursing assistant (NA)-A assisted R17 to sit on the edge of the bed, and cued her to grab onto the handles of her wheelchair. NA-A applied a gait belt to R17, and assisted her to stand up and turn to sit in her wheel chair. R17 was seated on the edge of her wheelchair and needed assistance to sit properly in the wheelchair, R17 stated, "Pull me up in back." NA-A adjusted R17 in the wheelchair for proper positioning, removed the gait belt, and completed morning cares. During interview on 1/28/15, at 7:42 a.m. NA-A stated she had always transferred R17 from her bed using only one person, but her ability to help during the transfers was becoming more difficult when R17 tired. During interview on 1/28/15, at 7:53 a.m. licensed practical nurse (LPN)-B stated R17 should be transferred using two people and a stand lift in the morning, and the care plan should have been followed, "You're supposed to follow the care plan." When interviewed on 1/28/15, at 9:19 a.m. the director of nursing (DON) stated R17's care plan should have been followed, and "education is needed immediately." A facility policy on care planning was requested, but none was provided.	F 282	• Education provided to all nursing staff on the importance and need to follow the written plan of care. • The DNS or designee will conduct weekly audits of the transfer process, then perform a monthly audit to ensure ongoing compliance. • The DNS or designee to perform random audits of transfer procedures for other residents in the facility to ensure the care plan is being followed. • The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance.	

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F 309	Continued From page 10	F 309	F 309	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess pain for 1 of 1 resident (R17) with pain and failed to provide proper wheelchair positioning for 1 of 3 residents (R17) who used a wheelchair. In addition, the facility failed to coordinate hospice services and identify what services were being provided for 1 of 1 resident (R20) who was receiving hospice services. Findings include: PAIN R17's quarterly Minimum Data Set (MDS), dated 10/30/14, identified R17 had moderate cognitive impairment, required extensive assistance with activities of daily living (ADLs), and experienced almost constant pain which she rated 7 out of 10 (10 being the worst pain experienced). When interviewed on 1/26/15, at 3:28 p.m. R17 stated she has arthritis and has chronic pain, and her, "back hurts all the time." R17 was unaware what medications she took for pain, or of any	F 309	It is the Policy of Golden Living Center Twin Rivers that the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The survey team concluded that R17 was not comprehensively assessed for pain and did not have proper wheelchair positioning. Also, R20's hospice services were not coordinated with facility services. Pain - Plan of correction: • R17 will have a new comprehensive pain assessment completed. After assessment is completed pain interventions will be reviewed and updated as necessary. Care plan and NAR care sheets will be updated and staff will be trained on pain modalities. • Education will provided to all staff on what the process is when a resident has signs/symptoms of pain or verbally expresses pain. • Pain assessments are completed quarterly on all residents. A review and audit of pain assessments and pain care plans on a sample of residents will be completed by DNS or designee. • To assure ongoing compliance and improvement is maintained DNS	

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F 309	Continued From page 11 interventions the staff did to reduce her pain. R17's Comprehensive Narrative Assessment, dated 11/5/14, identified R17, "shows s/s [signs and symptoms] of pain especially with transfers", and, "Consistently reports pain to her shoulders...Her goal is to have comfort with ADLs." Further, the assessment identified a plan of, "Assess for pain using pain scale", and, "Report any s/s [signs and symptoms] of unrelieved pain to PCP [primary care provider]." During observation of morning cares on 1/28/15, at 6:51 a.m. nursing assistant (NA)-A assisted R17 with personal hygiene, and roll over in bed. R17 had facial winces and stated, "ow, it hurts!" as she was assisted to roll in bed. NA-A dressed R17 and assisted her into a wheelchair so R17 could apply her make-up. R17 continued to complain of pain in her back and waistline. NA-A stated, she would tell the nurse and left the room at 7:24 a.m.. NA-A returned to R17's room at 7:25 a.m., and assisted R17 with brushing her teeth and wheeled her to the dining room for breakfast. When interviewed on 1/28/15, at 7:42 a.m. NA-A stated R17 frequently complaints of pain at all times during the day, "she has pain all the time." She tries to be gentle when giving care, but was unaware what interventions were in place to reduce or eliminate R17's pain but does notify the nurse about R17's pain. During interview on 1/28/15, at 9:51 a.m. licensed practical nurse (LPN)-B stated she had been assigned care for R17 that day, and verified she (R17) frequently complaints of pain and discomfort, "I know she's got bad arthritis."	F 309	or designee will complete weekly random pain audits. Wheelchair positioning – Plan of correction: • R17 will be offered a rescreening for wheelchair positioning by therapy. Family has been resistive in the past to therapy intervention. Nurse manager to also assess current wheelchair for comfort and provide interventions. • Other residents in the facility will be observed for proper positioning in wheelchairs and refer to therapy as indicated to assist with positioning. • Staff education will be provided in regards to proper wheelchair positioning and who to inform if a resident appears to have an ill-fitting wheelchair or complaints of discomfort with wheelchair. • Random audits will be completed weekly by DNS or designee for proper wheelchair positioning of residents. Hospice coordination – Plan of correction: • For R20 nurse manager or designee will coordinate with hospice provider to assure calendar is provided and completed in advance. Hospice will be educated in regards to what is expected in regards to coordination of care. Hospice staff will be expected to check in with facility staff when visiting R20.	

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F 309	Continued From page 12 Further, LPN-B stated nobody had reported to her that R17 had pain with morning cares that day, and it should be reported so we can address her pain. When interviewed on 1/28/15, at 10:08 a.m. R17 stated she was still having back pain and nobody had helped her do anything to relieve it. During interview on 1/29/15, at 9:00 a.m. LPN-D stated R17 has chronic pain, and NA-A should have alerted LPN-B within 5 to 10 minutes about her pain with morning cares. When interviewed on 1/29/15, at 9:25 a.m. the director of nursing (DON) stated resident complaints of pain should promptly be reported to the nurse to ensure appropriate follow-up, "I expect them to let the nurses know there was a complaint of pain." A facility policy on pain management was requested, but none was provided. WHEELCHAIR POSITIONING: R17's quarterly MDS, dated 10/30/14, identified she had moderate cognitive impairment, used a wheelchair for mobility, and required extensive assistance with locomotion, including wheelchair mobility, on the unit. R17's Therapist Progress & Discharge Summary, dated 3/14/14, identified, "Pt [patient] has a wheelchair positioning system which fits appropriately and corrects pelvic tilt which was causing patient pain. Pt has been seen self-propelling wheelchair in the hallway and has	F 309	• All other residents currently being followed by a hospice provider will have a review of their records to assure care is being coordinated and staff are aware of when hospice will be coming and services provided. • Education will be provided to hospice provider in regards to what is expected in regards to coordination of care. Facility staff will be trained in regards to where to locate hospice schedules and what services will be provided. • Audits will be completed monthly of residents to assure ongoing compliance of hospice coordination and communication. • The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance.	

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F 309	Continued From page 13 not reported any wheelchair concerns to staff." During observation on 1/26/15, at 3:35 p.m. R17 was seated in her wheelchair watching TV in her room. She was slouched in the chair, with her buttocks positioned towards the front of the chair seat, and her back pressed into the back support of the wheelchair. R17 stated she was uncomfortable and, "needs a decent chair." Subsequent observations of R17, on 1/28/15 at 8:05 a.m. and 1/29/15 at 8:05 a.m., all identified R17 seated in the same wheelchair in a slouched posture. When interviewed on 1/29/15, at 8:12 a.m. NA-G observed R17's positioning and stated she appeared slouched in the wheelchair. NA-G assisted R17 to sit back in the wheelchair, and stated there was several inches of space in between R17's lower back and the backrest of the wheelchair. Further, NA-G stated R17 should be referred to therapy for her positioning. During interview on 1/29/15, at 8:35 a.m. NA-H stated R17's wheelchair positioning had been poor since she was seen by therapy and her cushion was switched out. R17 is slouched many times in her wheelchair, and had complained about this for quite some time. When interviewed on 1/29/15, at 8:38 a.m. LPN-B stated therapy had seen R17 in the past, but was not sure if her wheelchair positioning had been addressed. Further, if a resident has poor posture or complaints regarding their wheelchair, therapy should be contacted and a referral completed. During interview on 1/29/15, at 9:13 a.m. certified	F 309		

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F 309	Continued From page 14 occupational therapy assistant (COTA)-C stated R17 had been seen in March 2014 for wheelchair positioning, however at times seems to slouched in her wheelchair. If staff had noticed concerns about her wheelchair positioning, or a resident complains of pain, therapy should have been contacted to do a re-screening of her wheelchair positioning. When interviewed on 1/29/15, at 9:25 a.m., the DON stated she was aware of positioning concerns for R17. Further, if a resident has complaints regarding their wheelchair, therapy should have been contacted, "They are my experts." A facility policy on wheelchair positioning was requested, but none was provided. HOSPICE: R20's admission Minimum Data Set (MDS), dated 12/17/14, identified R20 had moderate cognitive impairment, required limited assistance with activities of daily living (ADL), and had a prognosis of less than 6 months to live. R20's care plan, dated 12/16/14, identified R20 was on hospice care and had a goal of being comfortable and having her needs met. Further, the care plan identified interventions of, "Notify hospice of any change in condition", and "Coordinate Care Plan with Hospice". The care plan did not identify what specific services hospice was to be providing to R20 while at the facility. R20's undated Allina Hospice/Facility	F 309		

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F 309	Continued From page 15 Coordination of Care Plan identified a hospice social worker (SW) would visit R20 at the facility one time per month on the 3rd Monday of each month in the morning. A hospice nurse would visit R20 "1-5 x's [times] per week on M [Monday] & [and] Th [Thursday] pm." The form did not identify what cares the hospice staff would be completing for R20 when visiting her in the facility. During interview on 1/27/15, at 3:03 p.m. nursing assistant (NA)-L stated she was aware R20 was receiving hospice care, however was unsure what they did for her or when they visit, "I don't know what they do or are supposed to do." When interviewed on 1/27/15, at 3:05 p.m. NA-A stated she was unaware of what hospice was providing for R20, "I don't know." Further, NA-A was unaware how often hospice visited R20, or when they were next schedule to visit her, "I don't know, the nurses might know that." During interview on 1/27/15, at 3:08 p.m. licensed practical nurse (LPN)-D stated R20 had been on hospice care since admission to the facility, and hospice never calls prior to coming to the facility or had a particular schedule when they visit, "They usually just show up." Hospice uses an orange folder stored by the patient's chart for their communication, and they will write on a calendar after they visit R20, but not before coming to the facility. Further, the expectation is that hospice staff touch base with the facility staff regarding R20's care when they visit the facility. During interview on 1/27/15, at 3:16 p.m. LPN-B stated the hospice staff does not consistently touch base with the nurse caring for R20 when	F 309		

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F 309	Continued From page 16	F 309		

they visit, "They don't make it a point." Further, LPN-B stated she would like to be included on their visit and be made aware when they are coming to the facility, "I would like to know what is going on."

When interviewed on 1/27/15, at 3:23 p.m. RN-B stated she was not sure when hospice was supposed to visit R20 at the facility, "I believe they come once a week."

R20's Hospice & Palliative Care calendar, dated December 2014, identified a nurse had visited on 12/12/14 (Friday), 12/17/14 (Wednesday), and 12/23/14 (Monday). Further, R20 had "music therapy" on 12/22/14, but the form did not identify what staff completed it. The form did not identify if the hospice SW had visited R20 during this time. In addition, the form lacked the time of the visit for R20, and the nurse had not visited each Monday and Thursday evening as identified in the Allina Hospice/Facility Coordination of Care Plans form.

R20's Hospice & Palliative Care calendar, dated January 2015, identified a nurse had visited on 1/15/15 (Thursday), 1/19/15 (Monday), 1/20/15 (Tuesday), 1/21/15 (Wednesday), and 1/26/15 (Monday). The form did not identify a SW had visited R20 in January. In addition, the form lacked the time of the visit for R20, and indicated the nurse had not visited on Monday and Thursday evening as identified in the Allina Hospice/.Facility Coordination of Care Plans form.

R20's Facility Visit Records, dated 12/12/14 to 1/29/15, identified a SW had visited R20 since admission, and hospice had visited R20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 seventeen times since her admission to the facility. Further, the form provided the following areas to mark if the task was completed: "Collaborated/Coordinated POC [plan of care]" and, "Scheduled visit calendar current." However, the forms indicated the "Collaborated/Coordinated POC" occurred 8 of the 17 times when they visited, and the scheduled visit calendar had not been updated since 12/17/14. In addition, the form provided a space to indicate what facility staff had been contacted during hospice staffs visit, however there were 6 examples of not identifying which staff were contacted, or, 35% of the time hospice did not identify if they had spoken to facility staff, or who they had spoken with regarding R20's care. During interview on 1/28/15, at 1:46 p.m. the hospice RN (HRN)-A stated she did not consistently speak with the nurse caring for R20 as it was hard to locate them, "it's hit or miss." HRN-A will visit R20 when she can as sometimes she will need to help with a new admission or something else would come up, but "Monday is my for sure day", to visit R20. HRN-A stated the expectation is the facility staff know she is coming on Monday and any concerns the facility has could be left on a note in R20's chart. Further, HRN-A stated she felt the collaboration of R20's care was, "as good as it can be." Although R20 had been on hospice service since admission to the facility in early December 2014, the facility staff were unaware what care was being completed for R20 by hospice, nor when the hospice staff were to visit R20. There was no	F 309		

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F 309	Continued From page 18 indication the hospice agency consistently collaborated with the facility, and update their scheduled visit calendar so staff were aware of their visits to R20. When interviewed on 1/29/15, at 9:29 a.m. the director of nursing (DON) stated good collaboration should include good communication from the hospice to facility and vice versa, "I don't see that collaboration so much." Further, the expectation is to maintain good communication and be a resource for the facility and family of the resident, "they are an extension of our team." A facility policy on coordination of care with hospice was requested, but none was provided.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have medical justification for use of an indwelling urinary catheter for 1 of 2 residents (R34) reviewed with a catheter.	F 315	F 315 It is the Policy of Golden Living Center Twin Rivers that the facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrated that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate tract infections and to restore as much normal bladder function as possible.	

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F 315	Continued From page 19 Findings include: R34's quarterly Minimum Data Set (MDS), dated 10/12/15, identified R34 had moderate cognitive impairment, required extensive assistance for all activities of daily living (ADL)'s, and had an indwelling urinary catheter. During observation on 01/27/2015, at 2:32 p.m. R34's clothes and shoes were on, a urinary catheter tubing was coming out the bottom of R34's pant leg with amber colored urine. During an interview on 01/28/2015 at 7:47 a.m. registered nurse (RN)-A said R34 was admitted on 1/5/15 with an order to consult urology in 7-10 days. There was no indication that R34 had seen the urologist which was confirmed by RN-A. RN-A said the health unit coordinator (HUC) makes the appointment and she did not know why the appointment had not occurred. HUC-A joined the conversation and stated they were waiting to get him into a local urologist because the physician was good about getting new residents in for appointments quickly. The HUC-A agreed R34 had not gotten a timely appointment. An interview on 01/28/2015 at 11:30 a.m. director of nursing (DON) stated she would get a progress note from the clinic for the rationale or justification for R34's indwelling urinary catheter. Further she stated that R34 did not meet criteria for a urinary catheter. On 01/28/2015 at 12:09 a.m. health information manager brought a form dated 1/8/15. The Progress Note which was a history and physical only identified R34 had "Foley in draing clear	F 315	Plan of correction: • R34 had follow up appointment with urology as per MD discharge orders and catheter was successfully removed. R34 is discharging home with no catheter on 2/20/15. • New residents being admitted to facility will be reviewed for catheter use and medical need for necessity. If follow up urology appointment is ordered DNS or designee will ensure that appointment is made within the prescribed time. • Audits will be completed of other residents in facility to assure medical necessity is documented and meets criteria for indwelling catheter. • Education will be provided to licensed staff in regards to appropriate medical necessity for indwelling foley catheters. • Audits of new residents with foley catheters will be completed monthly by DNS or designee to ensure ongoing compliance. • The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance.	

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F 315	Continued From page 20 urine." There was no justification identified for the use of the catheter. Another document titled, Documentation of Medical Necessity for Use of Indwelling Catheter was a form, that identified specific categories of medical necessity for a urinary catheter. The form identified R34 had an x marked for "inability to manage urinary retention with intermittent catheterization. Medical condition present which prevents intermittent catheterization" which was left blank. A summary of the urologist evaluation identified, "Admit orders state cath is to remain in place until F/U [follow up]. Urinary retention, continue Foley, follow up with urology for voiding trial." There was no justification for the use of the catheter, nor was there any indication of how much urine retention if any R34 had. An interview with the DON on 01/29/2015 at 12:45 p.m. verified the above note did not identify a rationale for the indwelling urinary catheter being used by R34. A progress note dated 1/19/15 and 1/14/15 authored by his nurse practitioner (NP) indicated "a Foley catheter is in place". There was no justification of why R34 had an indwelling urinary catheter. An undated but signed standing orders sheet indicated, "discontinue urinary catheter unless the admitting history and physical indicates a diagnosis of neurogenic bladder, prostate hypertrophy with obstruction or urinary retention." The admitting history and physical did not indicate any of the above approved conditions for the catheter.	F 315		

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F 441 F 441 SS=D	Continued From page 21 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F441 It is the Policy of Golden Living Center Twin Rivers that the facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of correction: • Education in regards to infection control and appropriate manner to complete a bed bath will be provided to NAR providing care to R17. • Education will be provided to all staff in regards to infection control during a partial bath and the correct sequence to complete partial bath. • NAR care audits will be completed weekly for 4 weeks and then monthly by DNS or designee. Audits will be completed on random NARs to ensure ongoing compliance with regulation. • The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/6/15 The DNS is responsible for monitoring compliance.	

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F 441	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal care was provided in a sanitary manner for 1 of 3 residents (R17) who were observed during personal cares. Findings include: R17's quarterly Minimum Data Set (MDS), dated 10/30/14, identified R17 had moderate cognitive impairment, and required extensive assistance from staff to complete personal hygiene. During observation of morning care on 1/28/15, at 6:51 a.m. nursing assistant (NA)-A filled a basin with soap, water and two washcloths. NA-A provided R17 a wet washcloth from the basin to wash her face, and returned it to the basin when completed. NA-A removed the washcloth from the basin and completed perineal cares for R17, placing the soiled washcloth back into the basin when completed. NA-A then helped R17 select clothing to be worn for the day, and removed the soiled washcloth from the basin and washed underneath R17's arms and the rest of her exposed body which was in the same water she used to complete peri care for R17. NA-A returned the soiled washcloth to the basin and continued dressing R17, and assisted her down to the dining room for breakfast. When interviewed on 1/28/15, at 7:42 a.m. NA-A stated she shouldn't have used a wetted cloth from the same soiled basin which was used to complete perineal care. She stated this was her	F 441		

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F 441	Continued From page 23 typical practice, "That's what I do." During interview on 1/29/15, at 10:21 a.m. the director of nursing (DON) stated R17 should not have been bathed in that manner, and residents should be bathed from the top of the body down. A facility Bath, Partial policy, dated 1/26/15, identified a procedure of, "Wash, rinse and dry neck, arms and armpits well", followed by, "Wash, rinse and dry back, buttocks and genitals."	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 sq ft of floor space per resident in 8 of 28 resident rooms (rooms 4, 7, 17, 20, 21, 29, 35 and 36) which affected 14 residents (R91, R38, R72, R46, R21, R61, R18, R27, R1, R12, R50, R48, R39, R14) who currently resided in these rooms. Findings include: During the entrance conference at 12:15 p.m. on 1/26/15, the facility's executive director stated rooms 4, 7, 17, 20, 21, 29, 35 and 36 remain the same size and "nothing has changed." He stated he would be applying for a waiver for these requirements.	F 458	F458 Golden LivingCenter-Twin Rivers would like to request a waiver under F458 in regard to resident room size. The rooms to be included in this waiver are 4, 7, 17, 20, 21, 29, 35, and 36. • These rooms were constructed in 1962 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility. • Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The residents' health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. • The Director of Maintenance is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	

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F 458	Continued From page 24 The following double resident rooms did not meet the required minimum square footage per resident: Room 4 = 150 square feet, 75 square foot per resident, R38 and R91. Room 7 = 152.5 square feet, 76.2 square foot per resident, R72. Room 17 = 150 square feet, 75 square foot per resident, R46 and R21. Room 20 = 150 square feet, 75 square foot per resident, R61. Room 21 = 150 square feet, 75 square foot per resident, R18 and R27. Room 29 = 150 square feet, 75 square foot per resident, R12 and R1. Room 35 = 150 square feet, 75 square foot per resident, R50 and R48. Room 36 = 155 square feet, 77.5 square foot per resident, R39 and R14. R14 who lived in room 36 was interviewed at 11:29 a.m. on 01/29/2015, and stated, why would I need more room? I think it would be more expensive with a larger room. "I would not want a larger room". What would I do with more room? I like this room? R61 was interviewed on 01/29/2015, at 11:00 a.m. who lives in room 20 stated my room is fine and had no concerns.	F 458		

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F 458	Continued From page 25 R1 stated on 01/29/2015, at 11:06 a.m. who lives in room 29 stated my room is fine and had no concerns. During an interview on 01/29/2015, at 9:53 a.m. with licensed practical nurse (LPN)-A stated she has had no problems with the room size of the rooms on the unit she usually works. She had not heard of any nursing assistant having problems with equipment in resident room 4, 7, and 17. An interview on 01/29/2015, at 9:57 a.m. LPN-B stated there were no complaints or concerns about the resident room sizes. An interview with LPN-C on 01/29/2015, at 10:07 a.m. the rooms size has not caused any problems with patient care or struggles for the staff. During an interview on 01/29/2015, at 9:55 a.m. maintenance manager stated he had never had any complaints from the residents or staff about not being able to use equipment or anything else. An interview on 01/29/2015, at 10:24 a.m. the director of nursing stated she has not had any problems or complaints regarding the room size of the above named rooms. She also said they are careful about where they place residents and do not use those rooms if more space is required for resident care During an interview on 01/29/2015, at 10:00 a.m. with the administrator stated we will be filing for a wavier, we have always got one in the past.	F 458		

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

F5298023

PRINTED: 02/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	308 FREMONT STREET ANOKA, MN 55303

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Twin Rivers was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	K021 It is the policy of Golden Living Center Twin Rivers to ensure that any door in an exit passageway, stairway, enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: • Required manual fire system; • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • The automatic sprinkler system. The surveyor found that the stairwell door leading to the basement did not latch close and was glued open. Corrective action was taken January 30 when the maintenance director replace the	

POC ok
K 2-23-15

EXIT: 1-29-15 DC: 2-19-15

RECEIVED
FEB 20 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Rose | TITLE: Executive Director | (X6) DATE: 2/20/15

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

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

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	245298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/03/2015

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 1-story building was constructed in 1962 and was determined to be of Type II (111) construction. With an addition of the same type in 1977. It has a partial basement and is automatic sprinkler protected throughout. The facility has fire alarm detection in corridors and spaces open to the corridor that is monitored for fire department notification. All smoke barriers meet LSC (00) Section 8.3.2 Exception. The facility has a capacity of 56 and had a census of 50 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as edivenced by:	K 000	latch mechanism and verified that the latch closes properly. The maintenance director will monitor this door daily to ensure that the latch works properly and the safety standard is met. Date of completion: March 6, 2015 The Executive Director is responsible for monitoring compliance	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:	K 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 2 a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to meet the requirements of NFPA 101, 2000 Edition Sections 19.2.2.2.6 and 7.2.1.8.2. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/03/2015, observation revealed that the stair door leading to the basement does not latch closed. It appears that the latch mechanism has been glued open. This deficient practice was verified by the maintenance director at the time of the inspection.	K 021	K072 It is the Policy of Golden Living Center Twin Rivers that means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. The survey tour revealed that linen carts, med carts, wheelchairs and patient lifts were stored in the corridors throughout the facilility which were judged to be interfering with the convenient and effective removal	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 3 exits. access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/03/2015, observation revealed that there are linen carts, med carts, wheelchairs and patient lifts being stored in the corridors throughout the facility. This deficient practice was verified by the maintenance director at the time of the inspection.	K 072	of patients in an emergency situation. Our facility policy states that carts, lift equipment etc. used should be stored on one side of the hallway and only during the time the item is being used, for example when a laundry cart is being unloaded. We will educate all staff to this policy and monitor the hallways to assure compliance. Date of completion: March 6, 2015 The Executive Director is responsible for monitoring compliance	