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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 53FD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **286742700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND CARE CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

4. TYPE OF ACTION: **7** (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 **12/5/2012** (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 IMR	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 **164** (L18)

13.Total Certified Beds **164** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	164			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sarah Grebenc, Unit Supervisor — 01/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Nicole Steege, Program Specialist — 01/11/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(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.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/17/2012
(L33)

DETERMINATION APPROVAL

CCN: 24-5186

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on October 23, 2012, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On December 5, 2012, the Minnesota Department of Health completed a Post Certification Revisit (by review of the plan of correction) and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on October 23, 2012, effective November 27, 2012. Therefore, the remedies outlined in our letter dated November 2, 2012 will not be imposed. See attached CMS-2567B for the results of the December 5, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245186

January 11, 2013

Ms. Kristina Guindon, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

Dear Ms. Guindon:

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 November 27, 2012 the above facility is recommended for:

164 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all164 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,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 11, 2013

Ms. Kristina Guindon, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

RE: Project Number S5186027

Dear Ms. Guindon:

On November 2, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 19, 2012. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 5, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 19, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 27, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2012, effective November 27, 2012 and therefore remedies outlined in our letter to you dated November 2, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245186	A. Building B. Wing	12/5/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **11/27/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **11/27/2012**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **11/27/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/27/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/27/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/NCS	1/11/13	28589	12/5/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/19/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 53FD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **286742700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND CARE CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

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 **10/19/2012** (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 IMR	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 **175** (L18)

13.Total Certified Beds **175** (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	IMR
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marilyn Kaelke, HFE-NEII 11/19/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 12/14/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(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.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on October 19, 2012, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit after November 27, 2012.

Additionally, an investigation of complaint numbers H5186195 & H5186196 were completed at the time of the recertification survey, which were found to be unsubstantiated.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8748

November 2, 2012

Ms. Kristina Guindon, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

RE: Project Number S5186027, H5186195 & H5186196

Dear Ms. Guindon:

On October 23, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 19, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5186195 & H5186196 that were found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

Informal Dispute Resolution - 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:

Sarah Grebenc
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7365

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 November 28, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 19, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 19, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

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
	245186	A. BUILDING _____ B. WING _____	C 10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5186196 and H5186195 were completed. The complaint is not substantiated.	F 000	Disclaimer For Plan of Correction Golden Valley Rehabilitation and Care Center objects to the allegation of non-compliance. 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 by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Golden Valley Rehabilitation and Care Center respectfully makes its allegation of compliance on all areas and has written these Plans of Correction to constitute the allegation. The Center is alleging compliance on November 27, 2012.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is	F 156	F156 1.) The identified resident has been discharged from the facility per his choice. 2.) Effective August 2012, GVRCC has issued Notice of Medicare Non-Coverage to all residents upon d/c from facility if they were covered by Medicare A benefits.	11/27/12

11/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NHA | 11/14/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 10/19/2012

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GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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F 156	Continued From page 1 entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	F 156	3.) Education completed on policy and procedure with NHA, BOM, SS, and CRC. 4.) Weekly audits of residents discharged receiving utilizing their Medicare A benefit. 5.) Audit results will be reviewed by facility QA committee. 6.) Clinical Reimbursement Coordinator (CRC) is responsible for compliance.	11/27/12 11/27/12 11/27/12

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F 156	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate liability and appeal rights notice upon termination of Medicare Part A benefits for 1 of 3 residents (R128) reviewed in the sample for liability notices and beneficiary appeal rights review. Findings include: R128 was admitted to the facility on 4/6/12, with diagnoses that included an above the knee amputation. R128 was discharged to home on 5/8/12. A review of R128's physical therapy (PT) Assistant Progress Update notes, dated 5/4/12, revealed, "The pt [patient] may D/C [discharge] home with Daughter affective 5/8/12". The PT Progress Report and Discharge Summary, dated 5/7/12, indicated R128 would be discharged from physical therapy on 5/7/12, with benefit days remaining. R128's medical record revealed the facility had not provided the Centers for Medicare and Medicaid Services (CMS) form 10123 to inform R128 or his legal representative of his right to an expedited review of service termination following termination of all Medicare Part A services for coverage reasons. During interview on 10/18/12, at 2:25 p.m., the minimum data set (MDS) coordinator verified she was responsible for providing liability notices and appeal rights for Medicare beneficiaries within the facility. MDS coordinator verified it was her understanding and the facility's practice that denial and appeal rights notices were not required for residents who remained on Medicare Part A	F 156		

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F 156	Continued From page 4 from admission to discharge and discharged to home. MDS coordinator verified the CMS form 10123 had not been provided to R128 or his legal representative. On 10/18/12, at 3:00 p.m., MDS coordinator reported that R128 would have remained eligible for Medicare Part A services, had he chosen to remain in the facility, based on restorative and skilled nursing needs. The facility's Expedited Review, Notice of Medicare Non-Coverage Procedure revised 4/12 identified the facility would notify Medicare beneficiaries of its decision to terminate Medicare Part A, no later than two days before coverage of services was terminated.	F 156		
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 interview and document review, the facility failed to ensure privacy was provided during personal cares for 1 of 3 residents (R130) reviewed in the sample for privacy. Findings include: R130 was re-admitted on 05/03/12, with diagnoses that included stage IV chronic kidney disease and peripheral vascular disease. The 30 day Minimum Data Set (MDS) assessment, dated 08/15/12, indicated R130 was alert and oriented and was cognitively intact. In addition, it also	F 241	F241 1. Resident's was interviewed and his careplan was updated with his privacy curtain preference. 2. Interviewable residents will be interviewed regarding any potential concerns they may have regarding privacy. 3. Staff education was completed on F241. 4. Caring partner checklists will be audited weekly. 5. Audit results will be reviewed by facility QA committee. 6. NHA is responsible for compliance.	11/27/12

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F 241	Continued From page 5 indicated R130 required minimal assistance of encouragement, supervision and cues from staff for personal hygiene and dressing needs. R130 required one person physical assist for walking in his room. On 10/17/12, at 1:30 p.m., R130 voiced concerns regarding nursing staff not providing him privacy during morning cares. R130 indicated that he preferred to wash himself in the mornings, at his bedside, to sustain his independence and staff would leave his room door wide open for people who passed by to view him naked. R130 expressed his frustrations and said no one would want others to see them naked and that despite his multiple requests to have his room door shut, the staff did not do it. On 10/17/12, at 2:14 p.m. Unit Manager, Registered Nurse, RN (B) verified that nursing assistants (NAR) did not always shut residents' room doors and needed reminders when RN (B) would conduct audits of cares. RN(B) indicated that NARs may need further education on importance of ensuring privacy during cares.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 250	F250 1.The family's goals and expectations of care, services, and prognosis were documented in resident's record. 2.) Residents with family as decision makers will have goals of care documented in their record. 3.) Staff education will be completed on F250 requirements. SS staff education on F250 and EHSI SS assessment policy. 4.) Weekly audits of SS assessment to ensure family goals of care are addressed. 6.) Administrator is responsible for compliance.	11/27/12

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F 250	Continued From page 6 review, the facility failed to effectively communicate with a family the goals for one of three residents (R262) reviewed for social services in regards to expectations of care and services and prognosis for R262. Findings include: R262's family voiced concerns regarding care given and did not feel their requests were honored or respected. The facility did not effectively communicate with the family goals for R262 and expectations for prognosis. R262 was admitted to the facility on 7/20/12, with diagnoses that included unspecified cerebral artery occlusion with cerebral infarction (stroke). The admission minimum data set (MDS) was completed on 7/27/12, and indicated R262 was not comatose but did not speak and rarely understood others. English was her second language and needed the services of a translator. Her short and long term memory was impaired and she was considered severely cognitively impaired. R262 was totally dependent on two staff for all activities of daily living (ADL) and was tube fed. The care area assessment (CAA) completed on 7/31/12, noted she had a legal guardian to assist with decision making. The CAA referenced R262 was admitted to the facility following hospitalization for breast cancer with brain metastasis and brain surgery. She was unable to communicate related to her medical condition and has a trach (tracheostomy) and received oxygen continuously.	F 250		

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F 250	Continued From page 7 R262's husband and son were interviewed on 10/16/12, at 8:34 a.m. They reported being very upset about the care given to R262 and verbalized that nursing staff unnecessarily tried in put in a Foley catheter that was not needed and administered unnecessary medications to the resident. They indicated R262 could not speak for herself and therefore they felt a family member needed to be in the resident's room almost continuously to ensure that she was given adequate care. R262's son reported he felt the facility was not doing an adequate job "assessing his mother's needs" and administrative facility staff were making decisions about his mother's care without family input and without adequate knowledge of her medical conditions. A review of the medical record noted a notation on the front of the chart which indicated that R262's family requested that all changes in R262's treatment be discussed with them. During the interview on 10/16/12, at 8:34 a.m. the family stated that approximately four to five days earlier, a nurse came into the room, and prepared to insert a catheter. When questioned, the nurse did not know the rationale for this, other than they were told the director of nurses (DON) had order them to do so. The resident's son reported during the interview that his mother had a catheter upon her admission to the facility and upon recommendation of a urologist, who had examined R262, it had been discontinued. R262's son stated this was a victory for his mother and did not want a catheter re-started. The family met with the DON on 10/14/12, and after the discussion, the DON contacted the resident's urologist and the order was rescinded.	F 250		

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F 250	Continued From page 8 The family stated they were upset that this was not discussed with them prior to getting an order to insert the catheter. The family also reported during the interview on 10/16/12, that R262 was subjected to unnecessary Tuberculosis testing. They indicated a nurse administered a Mantoux (a test for Tuberculosis) even though they strongly disagreed with the test and asked that it not be given to R262. They indicated R262 had two Mantoux's shortly after her admission to the facility and they felt the additional testing was unnecessary. R262's son verbalized to the nursing staff that the testing had already been done and should not be repeated but the test was administered. During an observation on 10/18/12, at 7:45 a.m. registered nurse (RN)-C was observed to enter the room on with an insulin syringe and proceeded to tell R262's husband of her intention of administering insulin to the resident as her blood sugar was 119. R262's husband refused to allow her to do so and stated her (R262) "blood sugar results were within a normal range" and R262 did not need any insulin. During that time, a laboratory (lab) staff member came to the resident's door and informed the husband of his intentions to draw blood on R262 to complete lab testing that was ordered by the physician. When the husband asked for clarification of the lab test that was to be done, the lab personal refused to discuss it with the husband. The lab member left the room and returned with RN-C. RN-C informed R262's husband what test was ordered by the physician but was unable to specify the rationale for the lab test. R262's husband refused to allow the lab test to be completed.	F 250		

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F 250	Continued From page 9 Nursing assistant (NA)-D was interviewed on 10/18/12, at 8:44 a.m. and verified R262's family is very involved with resident care and find staff to reposition resident if repositioning has not been done in two hours. She verified the family requested that nursing assistants document in a log the times when R262 is repositioned and the family does keep close eye on the times of repositioning. She indicated that generally the family is pleasant to all the nursing staff. Registered nurse (RN)-C was interviewed on 10/18/12, at 8:30 a.m. and verified R262's husband had been very angry at her earlier in the day. She indicated that he was concerned about the resident's breathing. She reported she assessed the resident and did not find the resident in any respiratory distress but did superficial suctioning of the tracheostomy with minimal return. She also reported that husband was upset about blood he observed on R262's sleeve and RN-C thought "he was afraid of blood." She indicated that generally R262's husband and family are generally cooperative and was surprised by his reaction earlier today. The DON was interviewed on 10/18/12, at 12:30 p.m. and verified she was aware of family's concerns. She reported R262's had been given a third Mantoux, which was not needed as staff had forgotten to transcribe the administration of the Mantoux to the immunization record. She also reported that she had completed a chart audit of the resident's condition on 10/14/12, and had determined R262 was declining. She then contacted R262's physician and expressed concern regarding potential skin breakdown and requested the physician insert a Foley catheter.	F 250		

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F 250	Continued From page 10 The DON indicated she was of aware of the family's decision to refuse medication and lab testing at times, which she respected. The DON did not make any indication however, there were conversations held with the family in regards to the family's expectations of care and treatment for R262. An interview with the social services supervisor (SW)-A was completed on 10/19/12, at 11:04 a.m. She reported not being aware of R262's family concerns, even though she attended "stand up" meetings every morning and "triage meetings" daily, where reports of residents conditions are discussed. She also reported that she will occasionally meet with R262's husband, but the discussions were generally very superficial, (discuss weather etc.) She reported she had talked to R262's husband on 10/19/12, and the husband had told her that family expected R262 to leave the facility walking. She indicated R262's family seemed to be having difficulty accepting the probably this would not happen and potentially R262 was terminal. She verified social services were not meeting with the family on a regular basis to discuss her medical condition or offered additional services to the family to aid them with the acceptance of R262 condition and prognosis. She also reported social services had not been involved with advocating for the family's requests with nursing staff and addressing the cultural issues presented.	F 250		
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	F 282	F282 1.) Resident is provided with oral care per plan of care. 2.) Residents' oral care needs will be identified on NAR care sheets and plan of care.	10/19/12

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F 282	Continued From page 11 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure services were provided in accordance with each resident's plan of care, related to oral hygiene for 1 of 3 residents (R29) reviewed in the sample for activities of daily living. Findings include: R29 diagnoses that included brain injury and dementia. The annual minimum data set (MDS) dated 9/20/12, revealed R29 required extensive assistance for all activities of daily living (ADLs), including eating and personal hygiene. The plan of care dated 10/8/12, revealed R29 instructed staff to provide physical assistance with oral care daily and as needed. The nursing assistant care sheet, undated, identified R29 required assist of one with ADLs. During observation on 10/18/12, at 8:13 a.m., nursing assistant (NA)-L and NA-M provided morning cares to R29 in her resident room. After transferring R29 to her wheelchair, NA-M was observed to utilize a dampened washcloth to briefly wipe R29's upper and lower gums. R29 was noted to be edentulous (without teeth). No further oral care was provided.	F 282	3.) Staff education will be completed on proper techniques when providing oral care. 4.) Weekly audits of oral care will be completed. 5.) Oral care audit results will be reviewed by facility QA committee. 6.) Director of Nursing is responsible for compliance.	11/27/12

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F 282	Continued From page 12 During interview on 10/18/12, at 12:28 p.m., case manager (CM)-B reported that NAs were trained to use a tooth brush for completion of oral cares, or at a minimum an oral swab with mouth wash for a resident who was edentulous. During interview on 10/18/12, at 12:32 p.m., NA-M verified that she did not use an oral swab for R29's oral cares the morning of 10/18/12. NA-M reported that she typically utilized a damp "toothette" or swab for R29's oral cares. NA-M added, "There were no swabs in her room, there were none in her drawer." The facility's procedure for ASSISTING WITH MOUTH CARE, undated, identified that oral cares to be provided to a resident who was edentulous. The procedure outlined that the resident was to be allowed to rinse with water or mouthwash and a soft toothbrush or sponge-tipped swab was to be used to clean the resident's gums, tongue and the insides of the cheeks.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide residents who were unable to carry out activities of daily living (ADLs), the necessary services to maintain good	F 312	F312 1. R29 will receive oral care according to plan of care. R141 will receive bathing assistance according to his plan of care. R14 was interviewed for preference and the plan of care was updated. 2. ADL preferences will be identified on NAR sheet for each resident. 3. Staff education was completed on oral care and bathing. 4. ADL audits will be completed weekly. 5. Audit results will be reviewed by facility QA committee. 6. DON is responsible for compliance.	10/19/12 11/27/12

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F 312	Continued From page 13 personal hygiene and address requests for additional bathing for 3 of 3 residents (R29, R141 and R14) reviewed in the sample for activities of daily living. Findings include: R29 was dependent upon staff assistance for personal hygiene and received inadequate oral care, as evidenced by observation on 10/18/12. R29 diagnoses that included brain injury and dementia. The annual minimum data set (MDS) dated 9/20/12, revealed R29 had moderately impaired cognitive skills for daily decision making and demonstrated signs and symptoms of delirium. The MDS also indicated R29 required extensive assistance for all ADLs, including eating and personal hygiene. The plan of care dated 10/8/12, revealed R29 instructed staff to provide physical assistance with oral care daily and as needed. The nursing assistant care sheet, undated, identified R29 required assist of one with ADLs. Continuous observations were made of R29 on 10/18/12, from 8:10 a.m. to 9:30 a.m. At 8:13 a.m., nursing assistant (NA)-L and NA-M provided morning cares to R29 in her resident room. After transferring R29 to her wheelchair, NA-M was observed to utilize a dampened washcloth to briefly wipe R29's upper and lower gums. R29 was noted to be edentulous (without teeth or dentures). No further oral care was	F 312		

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F 312	Continued From page 14 provided. R29 was then brought to the dining room, where NA-M was noted to provide R29 with assistance to eat. At 8:45 a.m., NA-M brought R29 out of the dining room and placed her wheelchair in the hallway outside her resident room, near the nurse's station. At 9:30 a.m., R29 remained in the hallway, with no additional oral cares provided. During an interview on 10/18/12, at 12:28 p.m., case manager (CM)-B reported that NAs were trained to use a tooth brush for completion of oral cares, or at a minimum an oral swab with mouth wash for a resident who was edentulous. CM-B added, "I don't think it would meet the standard to use a washcloth." During interview on 10/18/12, at 12:32 p.m., NA-M reported that she did not typically use a wet wash cloth for oral cares. She reported that she typically utilized a damp "toothette" or swab for R29's oral cares. NA-M verified that she did not use an oral swab for R29's oral cares the morning of 10/18/12. NA-M added, "There were no swabs in her room, there were none in her drawer." The facility's procedure for ASSISTING WITH MOUTH CARE, undated, identified that oral cares to be provided to a resident who was edentulous. The procedure outlined that the resident was to be allowed to rinse with water or mouthwash and a soft toothbrush or sponge-tipped swab was to be used to clean the resident's gums, tongue and the insides of the cheeks. The facility did not provide frequent bathing assistance to R141 who was totally dependent upon staff for bathing assistance.	F 312		

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F 312	Continued From page 15 R141 had diagnoses that included dementia. The quarterly minimum data set dated 9/14/12, identified R141 was severely cognitively impaired, did not reject any assistance with activities of daily living, and required physical assist of one staff member with bathing. During interview on 10/16/12, at 12:27 p.m. family-B stated R141 had gone for a week without his hair being combed. Family-B explained there had been something sticky such as syrup in the hair and when she tried to comb R141's hair, a bunch of it fell out. Family-B talked with staff about the hair, but upon returning a week later, the hair hadn't yet been washed. Family-B indicated this was not the first time R141 had gone a long time without proper care and explained when R141 first was admitted to the facility he went nearly a month without hair washing. Family-B state, "It's too bad as he really enjoys having his hair washed." The care plan dated 6/1/12, revealed R141 was to be neat, clean and well groomed daily. The care plan identified R141 required assistance with showering and combing hair. The nursing assistant care sheet indicated R141 was to be bathed on Friday mornings. The bathing care tracker report from 5/31/12 to 10/18/12 (20 weeks) revealed R141 received only 12 showers and 2 baths. From 6/29/12 to 7/31/12 (32 days) R141 only received one bed bath which occurred on 7/14/12. Further review of the care tracker report revealed that from 9/13/12 to 10/11/12 (30 days) only one shower was provided	F 312		

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F 312	Continued From page 16 to R141 on 9/28/12. During interview on 10/18/12, at 9:43 a.m., registered nurse (RN)-D indicated R141 frequently did well in the shower and was cooperative. RN-D was unable to provide an explanation as to why R141 was not bathed weekly. During interview on 10/18/12, at 10:15 a.m., nursing assistant (NA)-G recalled providing showers to R141 occasionally since admission and confirmed R141 was cooperative in the shower. NA-G remembered the last shower given on 10/11/12, because of the syrup in R141's hair. NA-G was unable to explain why R141 had missed so many showers. The facility did not provide assistance with activities of daily living to R14 who requested additional showers. R14 was admitted to the facility with a diagnosis that included morbid obesity. The admission Minimum Data Set (MDS) worksheet dated 5/26/12, identified it was somewhat important for R14 to choose between a bath, shower or sponge bath. The form identified R14 preferred a shower over a tub, bed or sponge bath. The quarterly MDS dated 8/22/12, identified that R14 was cognitively intact and required extensive assist of two staff for bathing. The 1st Floor Break Sheet indicated R14 received a bath on 10/13/12.	F 312		

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F 312	Continued From page 17 On 10/16/2012, at 8:23 a.m., R14 reported, "You only get one shower a week. I would like one every day but even two or three times a week would be okay." R14 went on to state, "I get a yeast infection because I don't get more frequent showers because I sweat. They wash you up every day. At home I always showered every day." R14 stated she told the nursing assistant who helped her take a bath last Saturday that she wanted a bath more frequently. During the interview a strong odor was noted on R14's side of the room. On 10/17/12, at 1:47 p.m. R14 stated, "I would still like more showers. Right now I get yeast build up because of my folds. It's so strong it just humiliates me. And I don't care what they say washing up in bed doesn't help, I need to shower more often." On 10/18/12, at 9:03 a.m. nursing assistant (NA) -K stated R14 received one bath a week on Saturdays. NA-K reported if a resident requested more than one shower a week the staff would accommodate. On 10/18/12, at 10:02 a.m. trained medication administrator (TMA)-A stated he worked on Saturday. TMA-A reported R14 liked to take a bed bath every day. On 10/18/12, at 12:23 p.m. R14 stated she received a shower on 10/13/12, by NA-C. R14 reported she also told NA-B on the evening of 10/17/12, that she wanted a shower more frequently. R14 stated she requested a shower on 10/17/12, but the staff did not have enough time, "which was understandable because they	F 312		

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F 312	Continued From page 18 were busy". R14 further stated she told staff many times she wanted a second or third shower a week because she felt like she smelled. R14 stated no one has ever gotten back to her on whether or not they could provide more than one shower a week. R14 verified she had not informed the case manager, but stated "haven't I told enough people, why aren't they telling him?" On 10/18/12, at 12:43 p.m. NA-B confirmed R14 requested a shower the evening on 10/17/12. NA-B stated she was scheduled for Saturday and staff did not have time to give her a shower the night of 10/17/12. NA-B stated R14 calls out almost every night requesting a shower. NA-B reported if R14 wanted to be scheduled for a second shower she should talk to the registered nurse (RN)-A. NA-B stated he did not bring R14's request to RN-A because that was not the process here. On 10/18/12, at 2:15 p.m. RN-A confirmed staff had not informed him of R14's request to take showers more frequently. RN-A stated staff should be let him know if a resident requests more frequent showers so the facility could work them into the schedule. RN-A verified R14 did have some issues with yeast due to her skin folds and understood her concern with wanting to be showered more frequently. On 10/18/12, at 2:36 p.m. NA-D confirmed she helped R14 with her shower on 10/13/12. NA-D verified R14 told her she would like to take a shower every other day or at least twice a week. NA-D stated she told R14 to tell RN-A because she only worked the weekend shift and RN-A was not on duty. NA-D verified the facility's process	F 312		

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F 312	Continued From page 19 was to tell the resident to let the RN-A case manager know and not inform the case manager themselves.	F 312		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastrostomy tube placement was checked prior to medication and nutritional supplements given for 1 of 1 resident (R262) reviewed during medication administration via a gastrostomy tube. Additionally, the facility failed to ensure that medications and nutritional feedings were administered according to the facility policy. Findings include: On 10/18/12, at 8:20 a.m. registered nurse (RN) -C was observed to administer fluids and nutritional supplements to R262, and did not check placement of the gastrostomy tube. In addition, RN-C used a large syringe to administer fluids, which included water and Jevity 1.5 nutritional supplement and pushed the liquids into the gastrostomy tube.	F 322	F322 1. R262 was assessed and had no adverse signs or symptoms as a result of observation. 2. Other residents with g-tube will identified and Treatment Sheets will be updated with procedures for g-tube. 3. Staff education will be completed on g-tube procedures. 4. Weekly audits of g-tube procedures will be completed. 5. Audits to be reviewed at facility QA committee. 6. DON is responsible for compliance.	10/18/12 11/27/12

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F 322	Continued From page 20 R262's physician orders specified that 250 cubic centimeters (cc) of free water and Jevity 1.5 (1 can) be administered through the gastrostomy tube (g-tube) four times per day with 50 cc of water before, during and after the feeding. RN-C was interviewed on 10/18/12, at 8:30 a.m. and verified she had forgotten to check the placement of the g-tube. She also reported that some nurses at the facility use gravity to administer medication via the g-tube and other nurses use the syringe method. RN-C reported she was unsure of what the facility's policy directed her to do. The director of nurses (DON) was interviewed on 10/18/12, at 2:13 p.m. She reported she expected all nursing staff who administered any fluid/medication via the g-tube to use the gravity method for administration and to check placement of the g-tube prior to introducing any liquid or medication. She provided a photocopy copy of pages from the Lippincott Nursing Manual as the facility's procedure for administration of enteral (tube) feedings. The provided document directed staff to check placement of the gastrostomy tube prior to administration of any liquid and if the staff used a large syringe, the syringe would be filled and allow fluid to flow through the tube into the stomach by gravity.	F 322		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329	F329 1. R31 had pharmacy chart review and IDT review of medications. R31 also had a comprehensive assessment. 2. Facility audit of other residents on antidepressant and antianxiety	11/27/12

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F 329	Continued From page 21 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify, assess and monitor clinical indications to evaluate the effectiveness and continued use of medications for 1 of 10 residents (R31) whose medication regimen was reviewed. Findings include: Resident (R31) was receiving xanax (used to treat anxiety and panic disorders) 0.5 milligrams (mg) three times daily as needed (PRN) for anxiety since 03/02/12, and trazodone (antidepressant) 25 mg daily at bedtime as needed for sleep since 01/26/10. Both	F 329	medications. Pharmacy recommendations and IDT review will be completed on these residents. 3. Social Worker and the Nurse Manager were re-educated on the guidelines of F329. Staff education on unnecessary meds and documentation of non-pharmacological interventions in MAR. 4. Weekly audit of compliance for residents on antidepressant and antianxiety medications. The MED committee will continue to monitor the implementation of interventions for medications. 5. Review of audits at facility QA committee. 6. Director of Nursing will be responsible for compliance.	11/27/12

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F 329	Continued From page 22 medications (xanax and trazodone) were administered without adequate monitoring. R31 was admitted to the facility on 02/14/2001, with diagnoses that included panic disorder, insomnia, schizophrenia and depression. An annual Minimum Data Set (MDS) assessment, dated 07/03/12, identified R31 as cognitively intact with no behavioral issues and multiple mood indicators (examples included: feeling down, little interest in activities, feeling tired and bad about self) were coded on the MDS. The current physician's order, dated 10/09/12, indicated R31 had been receiving xanax 0.5 mg three times daily as needed (PRN) for anxiety and trazodone 25 mg at bedtime PRN for sleep. In addition, R31 received scheduled doses of xanax 0.5 mg for anxiety every morning and trazodone 25 mg twice a day for anxiety. Although the facility provided the psychiatrist's and licensed social worker visits to R31 (twice in February, once in April, four times in May, once in July and once in August 2012), the documentation lacked a comprehensive evaluation of R31's specific anxious behaviors, sleep and awake patterns and review of facility staff's documentation on R31's specific panic/anxious episodes to justify the use of PRN xanax and trazodone medications. Medication Administration Records (MAR) from July 2012 to present were reviewed and indicated R31 used PRN xanax 28 times in July, 24 times in August, 21 times in September, and 11 times in October 2012. Trazodone PRN was used four	F 329		

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F 329	Continued From page 23 times in September 2012 and one time in October 2012. The medical record lacked appropriate monitoring of these medications, including specific anxious/panic behaviors exhibited by R31, any non-pharmacological interventions attempted and outcome of these interventions. In addition, the facility did not monitor all appropriate side-effects associated with use of these medications, for example orthostatic blood pressures. A "7 day sleep diary," record indicated staff monitored only three nights in May (5/11, 5/12, 5/13/12) of R31's sleep pattern, otherwise, there was no evidence the facility staff monitored R31's sleep/awake patterns to justify the use of Trazodone for sleep. On 10/18/12, at 1:00 p.m. and 1:45 p.m., Unit Manager, Registered Nurse, RN(B) stated R31 had diagnosis of anxiety, panic attacks and paranoid schizophrenia for many years and had been receiving these medications for a number of years. RN-B indicated the resident did not exhibit explosive behaviors, rather would alert the nursing staff on how she felt and would request for PRN medications. RN-B added, the nursing staff documented in the progress notes and in care tracker (computerized documentation) when administered PRN medications. After reviewing the progress notes and the care tracker data, RN-B verified that appropriate monitoring documentation, including side-effect monitoring, was lacking for R31. Facility's "Psychoactive Medication" policy/procedures, revised on October 2008, directed staff to monitor and document regularly on side effects, non-drug approaches, resident responses to interventions, and target symptoms.	F 329		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor refrigerator temperatures that held potentially hazardous food to minimize the risk of food borne illness. This had the potential to affect 74 of 153 residents who received supplemental snacks. Findings include: A review of the Equipment Temperature Log for the last five months identified the facility did not have a system in place to ensure all refrigerators, primarily the nutritional supplement refrigerator, had been monitored for proper holding temperatures. During the initial kitchen tour on 10/15/12, at 1:32 p.m. the dietary manager (DM) and registered dietitian (RD) were unable to locate a thermometer in the nutritional supplemental refrigerator. DM confirmed this refrigerator held potentially hazardous foods such as an assortment of deli meat, cheese, yogurt, chicken	F 371	F371 1. Temperature of nourishment refrigerator was immediately checked to validate it was at appropriate temperature. 2. Temperature logs are in place for all refrigerators in the kitchen. 3. Staff were educated on F371 requirements. 4. Temperature logs will be audited for compliance with policy. 5. Audit results will be submitted to the facility QA committee for review. 6. Dietary Manager is responsible for compliance.	10/15/12 10/15/12 11/27/12

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F 371	Continued From page 25 salad, hard boiled eggs, and milk. On 10/15/12, at 1:34 p.m. the dietary manager (DM) confirmed the nourishment refrigerator temperature log indicated it had not been monitored for the last month. DM verified there was not a thermometer in the refrigerator to ensure potentially hazardous foods were held within the proper range to minimize the risk of bacterial growth and food borne illness. The facility's Refrigerator/Freezer Temperature Log Policy, indicated, "Extendicare Health Services, Inc., (EHSI) promotes the use of Refrigeration Temperature Log (Copy Form) as a temperature record for all refrigerator and freezers units taken twice daily on the AM and PM shifts in order to store foods safely and detect problems quickly."	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	F425 1.) Resident #292, has since discharged from the facility. All other cited residents are receiving their medications per order. 2.) All residents medication sheets were reviewed during the MDH survey. NHA and DON met with pharmacy 10/21/12 to review timeliness of medication delivery. 3.) Licensed staff were re-educated on the timely ordering of medications.	11/27/12

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F 425	Continued From page 26 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmaceutical services were secured, including routine medications and biologicals as ordered for 6 of 9 residents (R292, R161, R284, R51, R30 and R270), reviewed for missed medication doses due to medications not being available for administration. Findings include: Medication was not administered timely for R292 due to the medication being unavailable. R292 was admitted to the facility on 9/28/12, with diagnoses including closed fractures of the patella and upper humerus. Physician orders dated 9/28/12, revealed R292 was to receive oxycodone/ acetaminophen (Percocet) 5-325 mg, one to two tablets by mouth every four hours as needed for moderate to severe pain. On 10/17/12, at 12:25 p.m., R292 was observed to approach licensed practical nurse (LPN)-R and stated, "Have you got my Percocet yet?" When LPN-R replied, "No," R292 was noted to sigh loudly and shake her head. R292 then stated that this was the third time that the facility had run out	F 425	4.) DON or designee to audit 5 MAR's for missed doses on a weekly basis to identify any residents not identified in the medication error process. 5.) Audit results will be reviewed by the facility QA committee. 6.) DON is responsible for compliance.	11/27/12

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F 425	Continued From page 27 of her medication. LPN-R was asked about the facility's process for ordering medication from the pharmacy and whether they had difficulty getting medications in time to administer them as ordered. LPN-R verified the facility had run out of medications "at times" and had not received resident medications timely, to the point that residents had to miss doses of medications ordered by their physician. LPN-R reported that the facility's process for refilling medication was to remove the label from the medication "when it was getting close to running out." The label was then to be placed onto a sheet of paper and faxed to the pharmacy. LPN-R reported that if a medication was needed right away, the nurses were to call the pharmacy and request a stat order of the medication. LPN-R reported that she had typically been able to receive a stat medication order from the pharmacy within two hours of the request. LPN-R reported that there had been occasions when she had faxed a medication label to the pharmacy for refill and when she arrived for her next shift "a couple of days later," the medication had still not arrived and the resident had missed several doses as a result of the medication not being available. LPN-R reported that when she encountered these situations, she would call in a stat order to the pharmacy and received the medication within two hours. LPN-R reported that she was not sure why the delay was occurring, other than to guess that the re-fill date on the label may have indicated to the pharmacy that the medication did not need to be sent until that date. LPN-R indicated that she had reported this problem with medication refills to the unit care manager (CM) -E. LPN-R verified that she was awaiting a stat order for R292's Percocet.	F 425		

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F 425	Continued From page 28 During an interview on 10/17/12, at 12:40 p.m., R292 reported that she last received her Percocet at 7:00 a.m. and had requested another dose at 11:00 a.m., when she was told the facility was out of the medication. R292 identified her pain as an eight on a scale of one to 10. R292 stated, "It's awful... throbbing... aching... horrible." R292 described her pain as from her left shoulder/ neck area, down her arm and into her hand. She also reported pain in her right knee to quadriceps. R292 stated, "It is unacceptable," having to wait for her pain medication. Review of R292's Pain Flow Sheet from 10/1/12 to 10/17/12, revealed consistent pain ratings of 8 to 10 (on a scale of 10) prior to administration of as needed Percocet and pain ratings of 1 to 4 post administration of as needed Percocet. Review of medication administration record (MAR) for 10/1/12 to 10/17/12, revealed two tablets of Percocet 5-325 mg were last administered to R292 at 7:30 a.m. on 10/17/12. Review of progress note for R292, signed by LPN-R on 10/17/12, at 3:00 p.m. read, "At about 1030 [10:30 a.m.] resident asked for more pain pills, rates pain as 8/10, at the time pills were called to pharmacy to get them to come out on 1st run, hopefully stat. Resident was very upset when writer told her that 'the pills were on the way but could take up to 4 [four] hours to get here.' Resident [at] 12 Noon [12:00 p.m.] re-approached writer asking if pills have arrived yet... resident was still very upset, writer offered Tylenol to be given, but resident denied. At 1400 [2:00 p.m.] pain meds arrived, given 2, relief noted at 1500	F 425		

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F 425	Continued From page 29 [3:00 p.m.]." Six medication doses were missed for R161 due to the medication not being available for administration. R161 diagnoses included hypopituitarism (decreased secretion of hormones normally produced by the pituitary gland). Physician orders dated 9/29/12, revealed R161 was to receive an injection of genotropin, 0.4 mg daily for hypopituitarism. Genotropin was indicated for replacement of growth hormone. Review of the MAR for 9/1/12 to 9/30/12, revealed R161 was not administered the injection of genotropin as scheduled, at 8:00 a.m. on 9/1/12, 9/2/12, 9/3/12, 9/4/12, 9/5/12 and 9/6/12. Review of Medication Error Report dated 10/17/12, revealed the medication genotropin was not administered to R161 from 9/1/12 through 9/6/12, due to a delay in insurance coverage. No ill effects were noted as a result of these errors. Medication was not administered timely for R284 due to the medication being unavailable. R284 diagnoses included end stage renal disease and chronic anemia. The admission minimum data set (MDS) dated 9/20/12, revealed R284 was cognitively intact and received dialysis while a resident within the facility.	F 425		

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F 425	Continued From page 30 Physician orders dated 9/27/12, identified R284 was to receive calcium acetate (PhosLo), 667 mg (milligrams), four capsules by mouth three times daily with meals and at bedtime for end stage renal disease. PhosLo was indicated for control of hyperphosphatemia (a well-recognized risk factor for cardiovascular mortality in dialysis patients). On 10/17/12, at 12:10 p.m., R284 reported that the facility nurses were refusing to administer a medication that he needed in order to eat his lunch. R284 reported, "They're telling me they don't have the medication... that they're out of it." R284 reported that he needed the medication to help break down his food and he had to take the medication before he ate or he would get sick. R284 reported that lunch was scheduled to be served in the facility at 11:30 a.m. and he had to wait to eat because he had not received this medication. During interview on 10/17/12, at 12:15 p.m. LPN-R verified that she was going to administer R284's PhosLo at 11:00 a.m., but when she looked in her medication cart, she noticed that there were no PhosLo pills left in R284's medication bubble pack (pre-set up/ pre-packaged medication punch card). LPN-R reported that once she noticed there were no PhosLo pills left for R284, she called the pharmacy to request a stat delivery of the medication. LPN-R reported that the pharmacy had since called back and instructed her to check the medication cart to see if the same medication was available in the facility's stock medication bottles. LPN-R reported she had located the medication and was prepared to administer the	F 425		

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F 425	Continued From page 31 medication to R284. During observation on 10/17/12, at 12:30 p.m., LPN-R was noted to administer R284's PhosLo in the second floor dining room. R284 was then served his lunch, an hour after other residents had eaten. One medication dose was missed for R51 due to the medication not being available for administration. R51 diagnoses included gastrointestinal hemorrhage, heart disease and a history of superior mesenteric vein (SMV) thrombosis. Physician orders dated 9/29/12, revealed R 51 was to receive an injection of Fragmin 5,000 units per 0.2 ml (milliliters) daily, until fully ambulatory. Fragmin was indicated for deep vein thrombosis (DVT) prophylaxis. Review of the MAR for 10/1/12 to 10/17/12, revealed Fragmin was not administered to R51 on 10/9/12, with a note indicating the medication was not in stock. Review of Medication Error Report dated 10/17/12, revealed the medication Fragmin, scheduled for administration on 10/9/12, at 8:00 a.m. was missed. Reason for the error was noted as, "Not here ordered." The report noted the medication arrived from the pharmacy at 4:58 p.m. No complications arose from this medication error. R51's physician was notified of this missed dose on 10/17/12, at 12:00 p.m. Medication was not offered to R30 for timely	F 425		

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F 425	Continued From page 32 administration due to the medication not being available. R30 diagnoses included paranoid schizophrenia. Physician orders dated 10/3/12, revealed R30 was to receive an injection of fluphenazine decanoate (Prolixin Decanoate) 50 mg every two weeks (Monday overnight shift) for schizophrenia. Prolixin Decanoate was indicated as a long-acting antipsychotic for individuals with chronic schizophrenia. Review of the MAR for 10/1/12 to 10/17/12, revealed R30 was not administered the injection of Prolixin Decanoate as scheduled during the night shift on 10/9/12. Review of Medication Error Report dated 10/9/12, revealed the medication Prolixin Decanoate was not offered to R30 the morning of 10/9/12. The reason for error was noted as, "Not available for administration." No adverse reactions were noted from this error. R30's physician was promptly notified of this medication error. Review of progress notes for R30 from 10/9/12 through 10/11/12, revealed the Prolixin Decanoate was not administered on 10/9/12, but was reordered on 10/9/12. Subsequent notes indicated that once the medication was delivered by the pharmacy, R30 refused the injection multiple times successful administration on 10/11/12. Medication doses were missed for R270 due to the medication not being available for administration.	F 425		

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F 425	Continued From page 33 R270 diagnoses included depression. Physician orders dated 9/1/12 revealed R270 was to receive citalopram (Celexa) 20 mg daily for depression, via her feeding tube. Review of the MAR for 10/1/12 through 10/17/12, revealed R270 was not administered her daily 20 mg dose of Celexa on 10/14/12 and 10/17/12. The MAR also indicated that only a half dose was administered on 10/16/12. Review of Medication Error Report dated 10/17/12, revealed the medication Celexa was not administered as scheduled at 8:00 a.m. on 10/14/12 and 10/17/12. The report also indicated that only a half dose was administered on 10/16/12. The report noted that precautions taken to prevent similar errors included educating nurses to report missing doses. R270's physician was notified of these missed doses on 10/17/12, at 6:00 p.m. During interview on 10/17/12, at 12:50 p.m., CM-E verified the facility's process for refilling prescriptions from the pharmacy. She reported that she had taught the nurses to request refills at least 24 hours ahead of the time they were needed, by removing the label from the medication and faxing the label to the pharmacy. She reported she had also trained the nurses to call the pharmacy for a stat order if the ordered time for administration was drawing near. CM-E reported, to her knowledge, the longest the facility had to wait for a medication from the pharmacy was 48 hours. She denied being informed of any residents who had missed doses of medications	F 425		

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F 425	Continued From page 34 due to medications not being available. During follow-up interview on 10/17/12, at 1:25 p.m., LPN-R again verified that she had reported concerns of residents who had missed doses of medications ordered, due to the medications not being available. LPN-R verified she had reported this concern to CM-E. During interview on 10/18/12, at 5:21 p.m., director of nursing (DON) verified the facility was having "significant" issues with their contracted pharmacy. DON reported the pharmacy had not been allowing for automatic refills and was solely relying on facility staff to request the medication for the order to be filled. DON reported that the facility currently had a contract with the pharmacy to fill medications regardless of eligibility for insurance coverage for seven days (to be paid for by the facility) to ensure residents were receiving the medications they needed. DON reported that the pharmacy had not been honoring that contract. DON stated, "If there is no payer, no authorized place to bill, they will not fill the prescription," despite the facilities contracted agreement to cover seven days of medications in those circumstances. DON also indicated the facility was also having difficulty with the pharmacy "dropping orders" that were ordered to be on-going. DON reported that medication errors due to medications being unavailable for administration had been a more recent concern. She reported that the facility had identified some medication errors related to this concern prior to survey entrance, but was not aware of missed doses that nursing staff had not reported to her, until the time of the survey and all MARs were audited for missed doses due to medications	F 425		

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F 425	Continued From page 35 being unavailable for administration. DON reported it was her expectation that if a medication was not available for administration, the nurse would circle the dose missed on the MAR, write on the back of the MAR that the medication was not available and notify their supervisor so follow-up could occur and the physician could be notified. The facility's Medication Administration Procedure revised 7/10, instructed licensed nurses and/ or medication assistant's to indicate the reason for any dose omission in progress notes or on the back of the MAR. The policy noted, "It is not acceptable to omit a dose by indicating 'NA' for medication not available from pharmacy. Remove a dose from Back-up Supply/ Emergency Kit or contact pharmacy or on-call pharmacist and request medication to be sent ASAP [as soon as possible]. If the medication is not available, contact the physician for further orders."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	F428 1.) Resident #31 had her consultant pharmacist reports reviewed. Sleep assessment was completed. 2.) Facility will review all residents with antianxiety and hypnotic medications. 3.) Staff education on the guidelines in F428 and documentation requirements in Caretracker and nonpharmacological approaches and side effects. 4.) 5 audits will be completed weekly ensuring appropriate psychotropic documentation. 5.) Audit results will be brought to facility QA committee for review. 6.) DON is responsible for compliance.	11/27/12

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F 428	Continued From page 36 by: Based on interview and document review, the Consultant Pharmacist failed to ensure that 1 of 10 residents (R31) whose medications were reviewed included adequate monitoring of efficacy was in place. Findings include: Resident (R31) was receiving xanax (used to treat anxiety and panic disorders) 0.5 milligrams (mg) three times daily as needed (PRN) for anxiety since 03/02/12, and trazodone (antidepressant) 25 mg daily at bedtime as needed for sleep since 01/26/10. Both medications (xanax and trazodone) were administered without adequate monitoring. R31 was admitted to the facility on 02/14/2001 with diagnosis that included panic disorder, insomnia, schizophrenia and depression. An annual Minimum Data Set (MDS) assessment, dated 07/03/12, identified R31 as cognitively intact with no behavioral issues and multiple mood indicators (feeling down, little interest in activities, feeling tired and bad about self) were coded on the MDS. Current physician's order, dated 10/09/12, indicated R31 had been receiving xanax 0.5 mg three times daily as needed (PRN) for anxiety and trazodone 25 mg at bedtime PRN for sleep. In addition, R31 received scheduled doses of xanax 0.5 mg for anxiety every morning and trazodone 25 mg twice a day for anxiety. Although the facility provided the psychiatrist's	F 428		

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F 428	Continued From page 37 and licensed social worker visits to R31 (twice in February, once in April, four times in May, once in July and once in August 2012), the documentation lacked a comprehensive evaluation of R31's specific anxious behaviors, sleep and awake patterns and review of facility staff's documentation on R31's specific panic/anxious episodes to justify the use of PRN xanax and trazodone medications. Medication Administration Records (MAR) from July 2012 to present were reviewed and indicated R31 used PRN xanax 28 times in July, 24 times in August, 21 times in September, 11 times in October 2012. Trazodone PRN was used 4 times in September 2012 and 1 time in October 2012. The medical record lacked appropriate monitoring of these medications, including specific anxious/panic behaviors exhibited by R31, any non-pharmacological interventions attempted and outcome of these interventions. In addition, the facility did not monitor all appropriate side-effects associated with use of these medications, for example orthostatic blood pressures. A "7 day sleep diary," record indicated staff monitored four nights in May (5/11, 5/12, 5/13, 5/14/12) of R31's sleep pattern, otherwise, there was no evidence the facility staff monitored R31's sleep/awake patterns to justify the use of Trazodone for sleep. On 10/18/12, at 1:00 p.m. and 1:45 p.m., Unit Manager, Registered Nurse, RN-B stated R31 had diagnosis of anxiety, panic attacks and paranoid schizophrenia for many years and had been receiving these medications for a number of years. RN-B indicated that the resident did not exhibit explosive behaviors, rather would alert the nursing staff on how she felt and would request	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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F 428	Continued From page 38 for PRN medications. RN-B added, the nursing staff documented in the progress notes and in care tracker (computerized documentation) when administered PRN medications. After reviewing the progress notes and the care tracker data, RN-B verified that appropriate monitoring documentation, including side-effect monitoring, was lacking for R31. On 10/18/12, at 4:00 p.m. and 4:30 p.m.; the consulting pharmacist, after reviewing R31's medical record, verified the nursing staff needed to monitor and document on the use of psychotropic medications. The consulting pharmacist indicated the sleep assessment and monitoring were lacking for R31. The consulting pharmacist indicated that these issues needed to be brought to the attention of director of nursing and physician. Facility's "Psychoactive Medication" policy/procedures, revised on October 2008, directed staff to monitor and document regularly on side effects, non-drug approaches, resident responses to interventions, and target symptoms.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	F431 1.) The expired and undated medications were removed. Controlled substances are being appropriately locked. 2.) All medication carts and medication rooms were audited for improperly stored medications. 3.) Licensed staff were educated on medication storage.	11/27/12 11/27/12

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F 431	Continued From page 39 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure open medications were dated when open and expired medications were not administered for one of seven medication carts reviewed for medication storage. The facility also failed to keep controlled substances locked and accessible to authorized personnel only and stored medications with food items for one of five refrigerators that were reviewed for medication storage. Findings include:	F 431	4.) Med rooms will be audited weekly and 3 med carts will be audited weekly for compliance. 5.) Audit results will be submitted to facility QA committee. 6.) DON is responsible for compliance.	11/27/12

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F 431	Continued From page 40 On 10/15/12, at 1:45 p.m., a Byetta injectable pen (a prescription medicine that may improve blood sugar (glucose) control in adults with type 2 diabetes mellitus), was found in the first floor refrigerator in the medication storage room and was open; however, there was no open date on the medication. A review of the Amylin Pharmaceuticals, Inc. recommended storage guidelines indicated the Byetta Pen was to be used for only 30 days. After 30 days, the pen should be discarded even if there was some medicine left in the pen. Registered nurse (RN)-A verified no open date was on the pen and that it should have been dated when opened. During an observation of the first floor medication cart on 10/15/12, at 2:00 p.m., a vial of Heparin (a blood thinning medication used to prevent blood clots) was found in the top drawer. The multi-use vial had an expiration date of September 2012. The heparin had last been administered that morning on 10/15/12, at 8:00 a.m., 15 days past the expiration date. During continued review of the first floor medication cart, two dispensers of Advair Diskus (an inhaler used to treat asthma and chronic obstructive pulmonary disease) were found in the bottom drawer opened; however, the medication opened date labels were blank. RN-A stated Advair inhalers were to be dated when opened and each nurse was responsible for checking the medications for expiration and opened dates prior to administration. The GlaxoSmithKline (manufacturer of Advair)	F 431		

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F 431	Continued From page 41 recommended storage guidelines were to discard Adviar Diskus one month after removal from the foil pouch, or after the dose indicator reads "0", whichever comes first. Upon inspection of the unlocked refrigerator on the third floor dementia unit on 10/15/12, at 5:23 p.m., a multi dose vial of Ativan (a schedule IV controlled substance anti-anxiety medication) was found to be stored on the top shelf of the door. Also in the door was a multi dose vial of Tubresol (a medication used to aid in the diagnosis of a tuberculosis infection) which did not have an open date. Licensed practical nurse (LPN)-A immediately removed the vial of Ativan and placed it in the locked refrigerator in the third floor locked medication room. LPN-A stated the Tubresol needed to be thrown out because it had been opened and stored in a refrigerator that was used for food storage. LPN-A further stated the Ativan should not have been stored in the unlocked refrigerator. Review of the facility's Storage and Expiration Date of Medications, Biologicals, Syringes and Needles policy dated 5/10/10, revealed food is not to be stored in the refrigerator, freezer, or general storage areas where medication and biologicals are stored. The policy also indicated medications that have an expired date on the label should be stored separate from other medications until destroyed or returned to the supplier. Furthermore, the policy indicated the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications and that facility staff should record the date opened on the medication container when the medication has a shortened	F 431		

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F 431	Continued From page 42 expiration date once opened. Finally, the policy indicated the facility should ensure Schedule II-V controlled substances are only accessible to licensed nursing, pharmacy and medical personnel designated by facility. Review of the medication administration policy dated 7/10 revealed the licensed nurse and/or medication assistant were to verify the correct medication and expiration date prior to administration. During interview on 10/29/12 at 12:30 p.m., consulting pharmacist confirmed the Advair Diskus, Byetta and Tubresol medications should have been dated when opened. Consulting pharmacist also verified the expired vial of Heparin should have been discarded and should not have still been in use past the expiration date.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2012**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Valley Rehab and CC was found 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. This 3-story building was constructed in 1972 and was determined to be of Type II (222) construction. It has partial basement and is automatic fire sprinkler protected throughout. The facility has fire alarm detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 175 and had a census of 161 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8748

November 2, 2012

Ms. Kristina Guindon, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5186027, H5186195 & H5186196

Dear Ms. Guindon:

The above facility was surveyed on October 15, 2012 through October 19, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5186195 & H5186196, which were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. 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,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

PRINTED: 11/02/2012
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00112	A. BUILDING _____ B. WING _____	C 10/19/2012

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GOLDEN VALLEY REHABILITATION AND CAR	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 15, 16, 17, 18 and 19, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

Kim Cox NHA 11/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		

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2 565	Continued From page 2 Based on observation, interview and document review, the facility failed to ensure services were provided in accordance with each resident's plan of care, related to oral hygiene for 1 of 3 residents (R29) reviewed in the sample for activities of daily living. Findings include: R29 diagnoses that included brain injury and dementia. The annual minimum data set (MDS) dated 9/20/12, revealed R29 required extensive assistance for all activities of daily living (ADLs), including eating and personal hygiene. The plan of care dated 10/8/12, revealed R29 instructed staff to provide physical assistance with oral care daily and as needed. The nursing assistant care sheet, undated, identified R29 required assist of one with ADLs. During observation on 10/18/12, at 8:13 a.m., nursing assistant (NA)-L and NA-M provided morning cares to R29 in her resident room. After transferring R29 to her wheelchair, NA-M was observed to utilize a dampened washcloth to briefly wipe R29's upper and lower gums. R29 was noted to be edentulous (without teeth). No further oral care was provided. During interview on 10/18/12, at 12:28 p.m., case manager (CM)-F reported that NAs were trained to use a tooth brush for completion of oral cares, or at a minimum an oral swab with mouth wash for a resident who was edentulous. During interview on 10/18/12, at 12:32 p.m.,	2 565		

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2 565	Continued From page 3 NA-M verified that she did not use an oral swab for R29's oral cares the morning of 10/18/12. NA-M reported that she typically utilized a damp "toothette" or swab for R29's oral cares. NA-M added, "There were no swabs in her room, there were none in her drawer." The facility's procedure for ASSISTING WITH MOUTH CARE, undated, identified that oral cares to be provided to a resident who was edentulous. The procedure outlined that the resident was to be allowed to rinse with water or mouthwash and a soft toothbrush or sponge-tipped swab was to be used to clean the resident's gums, tongue and the insides of the cheeks. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide residents who	2 920		

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2 920	Continued From page 4 were unable to carry out activities of daily living (ADLs), the necessary services to maintain good personal hygiene and address requests for additional bathing for 3 of 3 residents (R29, R141 and R14) reviewed in the sample for activities of daily living. Findings include: R29 was dependent upon staff assistance for personal hygiene and received inadequate oral care, as evidenced by observation on 10/18/12. R29 diagnoses that included brain injury and dementia. The annual minimum data set (MDS) dated 9/20/12, revealed R29 had moderately impaired cognitive skills for daily decision making and demonstrated signs and symptoms of delirium. The MDS also indicated R29 required extensive assistance for all ADLs, including eating and personal hygiene. The plan of care dated 10/8/12, revealed R29 instructed staff to provide physical assistance with oral care daily and as needed. The nursing assistant care sheet, undated, identified R29 required assist of one with ADLs. Continuous observations were made of R29 on 10/18/12, from 8:10 a.m. to 9:30 a.m. At 8:13 a.m., nursing assistant (NA)-L and NA-M provided morning cares to R29 in her resident room. After transferring R29 to her wheelchair, NA-M was observed to utilize a dampened washcloth to briefly wipe R29's upper and lower gums. R29 was noted to be edentulous (without teeth or dentures). No further oral care was	2 920		

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GOLDEN VALLEY REHABILITATION AND CAR	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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2 920	Continued From page 5 provided. R29 was then brought to the dining room, where NA-M was noted to provide R29 with assistance to eat. At 8:45 a.m., NA-M brought R29 out of the dining room and placed her wheelchair in the hallway outside her resident room, near the nurse's station. At 9:30 a.m., R29 remained in the hallway, with no additional oral cares provided. During an interview on 10/18/12, at 12:28 p.m., case manager (CM)-F reported that NAs were trained to use a tooth brush for completion of oral cares, or at a minimum an oral swab with mouth wash for a resident who was edentulous. NA-F added, "I don't think it would meet the standard to use a washcloth." During interview on 10/18/12, at 12:32 p.m., NA-M reported that she did not typically use a wet wash cloth for oral cares. She reported that she typically utilized a damp "toothette" or swab for R29's oral cares. NA-M verified that she did not use an oral swab for R29's oral cares the morning of 10/18/12. NA-M added, "There were no swabs in her room, there were none in her drawer." The facility's procedure for ASSISTING WITH MOUTH CARE, undated, identified that oral cares to be provided to a resident who was edentulous. The procedure outlined that the resident was to be allowed to rinse with water or mouthwash and a soft toothbrush or sponge-tipped swab was to be used to clean the resident's gums, tongue and the insides of the cheeks. The facility did not provide frequent bathing assistance to R141 who was totally dependent upon staff for bathing assistance. R141 had diagnoses that included dementia.	2 920		

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2 920	Continued From page 6 The quarterly minimum data set dated 9/14/12, identified R141 was severely cognitively impaired, did not reject any assistance with activities of daily living, and required physical assist of one staff member with bathing. During interview on 10/16/12, at 12:27 p.m. family-B stated R141 had gone for a week without his hair being combed. Family-B explained there had been something sticky such as syrup in the hair and when she tried to comb R141's hair, a bunch of it fell out. Family-B talked with staff about the hair, but upon returning a week later, the hair hadn't yet been washed. Family-B indicated this was not the first time R141 had gone a long time without proper care and explained when R141 first was admitted to the facility he went nearly a month without hair washing. Family-B state, "It's too bad as he really enjoys having his hair washed." The care plan dated 6/1/12, revealed R141 was to be neat, clean and well groomed daily. The care plan identified R141 required assistance with showering and combing hair. The nursing assistant care sheet indicated R141 was to be bathed on Friday mornings. The bathing care tracker report from 5/31/12 to 10/18/12 (20 weeks) revealed R141 received only 12 showers and 2 baths. From 6/29/12 to 7/31/12 (32 days) R141 only received one bed bath which occurred on 7/14/12. Further review of the care tracker report revealed that from 9/13/12 to 10/11/12 (30 days) only one shower was provided to R141 on 9/28/12. During interview on 10/18/12, at 9:43 a.m.,	2 920		

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2 920	Continued From page 7 registered nurse (RN)-D indicated R141 frequently did well in the shower and was cooperative. RN-D was unable to provide an explanation as to why R141 was not bathed weekly. During interview on 10/18/12, at 10:15 a.m., nursing assistant (NA)-G recalled providing showers to R141 occasionally since admission and confirmed R141 was cooperative in the shower. NA-G remembered the last shower given on 10/11/12, because of the syrup in R141's hair. NA-G was unable to explain why R141 had missed so many showers. The facility did not provide assistance with activities of daily living to R14 who requested additional showers. R14 was admitted to the facility with a diagnosis that included morbid obesity. The admission Minimum Data Set (MDS) worksheet dated 5/26/12, identified it was somewhat important for R14 to choose between a bath, shower or sponge bath. The form identified R14 preferred a shower over a tub, bed or sponge bath. The quarterly MDS dated 8/22/12, identified that R14 was cognitively intact and required extensive assist of two staff for bathing. The 1st Floor Break Sheet indicated R14 received a bath on 10/13/12. On 10/16/2012, at 8:23 a.m., R14 reported, "You only get one shower a week. I would like one every day but even two or three times a week would be okay." R14 went on to state, "I get a yeast infection because I don't get more frequent	2 920		

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2 920	Continued From page 8 showers because I sweat. They wash you up every day. At home I always showered every day." R14 stated she told the nursing assistant who helped her take a bath last Saturday that she wanted a bath more frequently. During the interview a strong odor was noted on R14's side of the room. On 10/17/12, at 1:47 p.m. R14 stated, "I would still like more showers. Right now I get yeast build up because of my folds. It's so strong it just humiliates me. And I don't care what they say washing up in bed doesn't help, I need to shower more often." On 10/18/12, at 9:03 a.m. nursing assistant (NA) -K stated R14 received one bath a week on Saturdays. NA-K reported if a resident requested more than one shower a week the staff would accommodate. On 10/18/12, at 10:02 a.m. trained medication administrator (TMA)-A stated he worked on Saturday. TMA-A reported R14 liked to take a bed bath every day. On 10/18/12, at 12:23 p.m. R14 stated she received a shower on 10/13/12, by NA-C. R14 reported she also told NA-B on the evening of 10/17/12, that she wanted a shower more frequently. R14 stated she requested a shower on 10/17/12, but the staff did not have enough time, "which was understandable because they were busy". R14 further stated she told staff many times she wanted a second or third shower a week because she felt like she smelled. R14 stated no one has ever gotten back to her on whether or not they could provide more than one shower a week. R14 verified she had not informed the case manager, but stated "haven't I	2 920		

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2 920	Continued From page 9 told enough people, why aren't they telling him?" On 10/18/12, at 12:43 p.m. NA-B confirmed R14 requested a shower the evening on 10/17/12. NA-B stated she was scheduled for Saturday and staff did not have time to give her a shower the night of 10/17/12. NA-B stated R14 calls out almost every night requesting a shower. NA-B reported if R14 wanted to be scheduled for a second shower she should talk to the registered nurse (RN)-A. NA-B stated he did not bring R14's request to RN-A because that was not the process here. On 10/18/12, at 2:15 p.m. RN-A confirmed staff had not informed him of R14's request to take showers more frequently. RN-A stated staff should be let him know if a resident requests more frequent showers so the facility could work them into the schedule. RN-A verified R14 did have some issues with yeast due to her skin folds and understood her concern with wanting to be showered more frequently. On 10/18/12, at 2:36 p.m. NA-D confirmed she helped R14 with her shower on 10/13/12. NA-D verified R14 told her she would like to take a shower every other day or at least twice a week. NA-D stated she told R14 to tell RN-A because she only worked the weekend shift and RN-A was not on duty. NA-D verified the facility's process was to tell the resident to let the RN-A case manager know and not inform the case manager themselves. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with Activities of Daily Living. The DON or designee (s) could	2 920		

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2 920	Continued From page 10 provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastrostomy tube placement was checked prior to medication and nutritional supplements given for 1 of 1 resident (R262) reviewed during medication administration via a gastrostomy tube. Additionally, the facility failed to ensure that medications and nutritional feedings were administered according to the facility policy.	2 930		

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2 930	Continued From page 11 Findings include: On 10/18/12, at 8:20 a.m. registered nurse (RN) -C was observed to administer fluids and nutritional supplements to R262, and did not check placement of the gastrostomy tube. In addition, RN-C used a large syringe to administer fluids, which included water and Jevity 1.5 nutritional supplement and pushed the liquids into the gastrostomy tube. R262's physician orders specified that 250 cubic centimeters (cc) of free water and Jevity 1.5 (1 can) be administered through the gastrostomy tube (g-tube) four times per day with 50 cc of water before, during and after the feeding. RN-C was interviewed on 10/18/12, at 8:30 a.m. and verified she had forgotten to check the placement of the g-tube. She also reported that some nurses at the facility use gravity to administer medication via the g-tube and other nurses use the syringe method. RN-C reported she was unsure of what the facility's policy directed her to do. The director of nurses (DON) was interviewed on 10/18/12, at 2:13 p.m. She reported she expected all nursing staff who administered any fluid/medication via the g-tube to use the gravity method for administration and to check placement of the g-tube prior to introducing any liquid or medication. She provided a photocopy copy of pages from the Lippincott Nursing Manual as the facility's procedure for administration of enteral (tube) feedings. The provided document directed staff to check placement of the gastrostomy tube prior to administration of any liquid and if the staff used a large syringe, the syringe would be filled and allow fluid to flow through the tube into the stomach by gravity.	2 930		

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2 930	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could review the policies and procedures for the administration of medications and nutrution through the Gastrostomy Tube and could provide ongoing staff training regarding the administration of medications and nutrition through the GT. Ongoing audits of the procedure for all licensed staff could be performed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 930		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor refrigerator temperatures that held potentially hazardous food to minimize the risk of food borne illness. This had the potential to affect 74 of 153 residents who received supplemental snacks. Findings include: A review of the Equipment Temperature Log for the last five months identified the facility did not have a system in place to ensure all refrigerators, primarily the nutritional supplement refrigerator, had been monitored for proper holding temperatures.	21100		

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21100	Continued From page 13 During the initial kitchen tour on 10/15/12, at 1:32 p.m. the dietary manager (DM) and registered dietitian (RD) were unable to locate a thermometer in the nutritional supplemental refrigerator. DM confirmed this refrigerator held potentially hazardous foods such as an assortment of deli meat, cheese, yogurt, chicken salad, hard boiled eggs, and milk. On 10/15/12, at 1:34 p.m. the dietary manager (DM) confirmed the nourishment refrigerator temperature log indicated it had not been monitored for the last month. DM verified there was not a thermometer in the refrigerator to ensure potentially hazardous foods were held within the proper range to minimize the risk of bacterial growth and food borne illness. The facility's Refrigerator/Freezer Temperature Log Policy, indicated, "Extendicare Health Services, Inc., (EHSI) promotes the use of Refrigeration Temperature Log (Copy Form) as a temperature record for all refrigerator and freezers units taken twice daily on the AM and PM shifts in order to store foods safely and detect problems quickly." SUGGESTED METHOD FOR CORRECTION: The administrator with the director of food service could educate dietary staff on the importance of monitoring refrigerators for proper food holding. The director of food service or designee could monitor refrigerator temperatures on an ongoing basis to assure appropriate food temperatures are maintained. TIME PERIOD FOR CORRECTION: Seven (7) days.	21100		

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21470	Continued From page 14	21470		
21470	MN Rule 4658.1000 Subp. 1-3 Definitions- Social Services Subpart 1. Scope. For the purposes of this chapter, the following terms have the meanings given them. Subp. 2. Medically related social services. "Medically related social services" means services provided by the nursing home's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. Subp. 3.Qualified social worker. Until June 30, 1996, "qualified social worker" means an individual with at least a bachelor's degree in a social work or a human services field, with at least one year of supervised social work experience in a health care setting working directly with individuals. Effective July 1, 1996, "qualified social worker" means an individual licensed as a social worker by the Minnesota Board of Social Work according to Minnesota Statutes, chapter 148B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to effectively communicate with a family the goals for one of three residents (R262) reviewed for social services in regards to expectations of care and services and prognosis for R262. Findings include: R262's family voiced concerns regarding care given and did not feel their requests were	21470		

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21470	Continued From page 15	21470		

honored or respected. The facility did not effectively communicate with the family goals for R262 and expectations for prognosis.

R262 was admitted to the facility on 7/20/12, with diagnoses that included unspecified cerebral artery occlusion with cerebral infarction (stroke).

The admission minimum data set (MDS) was completed on 7/27/12, and indicated R262 was not comatose but did not speak and rarely understood others. English was her second language and needed the services of a translator. Her short and long term memory was impaired and she was considered severely cognitively impaired. R262 was totally dependent on two staff for all activities of daily living (ADL) and was tube fed.

The care area assessment (CAA) completed on 7/31/12, noted she had a legal guardian to assist with decision making. The CAA referenced R262 was admitted to the facility following hospitalization for breast cancer with brain metastasis and brain surgery. She was unable to communicate related to her medical condition and has a trach (tracheostomy) and received oxygen continuously.

R262's husband and son were interviewed on 10/16/12, at 8:34 a.m. They reported being very upset about the care given to R262 and verbalized that nursing staff unnecessarily tried in put in a Foley catheter that was not needed and administered unnecessary medications to the resident. They indicated R262 could not speak for herself and therefore they felt a family member needed to be in the resident's room almost continuously to ensure that she was given adequate care. R262's son reported he felt the

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21470	Continued From page 16 facility was not doing an adequate job "assessing his mother's needs" and administrative facility staff were making decisions about his mother's care without family input and without adequate knowledge of her medical conditions. A review of the medical record noted a notation on the front of the chart which indicated that R262's family requested that all changes in R262's treatment be discussed with them. During the interview on 10/16/12, at 8:34 a.m. the family stated that approximately four to five days earlier, a nurse came into the room, and prepared to insert a catheter. When questioned, the nurse did not know the rationale for this, other than they were told the director of nurses (DON) had order them to do so. The resident's son reported during the interview that his mother had a catheter upon her admission to the facility and upon recommendation of a urologist, who had examined R262, it had been discontinued. R262's son stated this was a victory for his mother and did not want a catheter re-started. The family met with the DON on 10/14/12, and after the discussion, the DON contacted the resident's urologist and the order was rescinded. The family stated they were upset that this was not discussed with them prior to getting an order to insert the catheter. The family also reported during the interview on 10/16/12, that R262 was subjected to unnecessary Tuberculosis testing. They indicated a nurse administered a Mantoux (a test for Tuberculosis) even though they strongly disagreed with the test and asked that it not be given to R262. They indicated R262 had two Mantoux's shortly after her admission to the facility and they felt the additional testing was unnecessary. R262's son verbalized to the nursing staff that the testing had already been	21470		

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21470	Continued From page 17 done and should not be repeated but the test was administered. During an observation on 10/18/12, at 7:45 a.m. registered nurse (RN)-C was observed to enter the room on with an insulin syringe and proceeded to tell R262's husband of her intention of administering insulin to the resident as her blood sugar was 119. R262's husband refused to allow her to do so and stated her (R262) "blood sugar results were within a normal range" and R262 did not need any insulin. During that time, a laboratory (lab) staff member came to the resident's door and informed the husband of his intentions to draw blood on R262 to complete lab testing that was ordered by the physician. When the husband asked for clarification of the lab test that was to be done, the lab personal refused to discuss it with the husband. The lab member left the room and returned with RN-C. RN-C informed R262's husband what test was ordered by the physician but was unable to specify the rationale for the lab test. R262's husband refused to allow the lab test to be completed. Nursing assistant (NA)-D was interviewed on 10/18/12, at 8:44 a.m. and verified R262's family is very involved with resident care and find staff to reposition resident if repositioning has not been done in two hours. She verified the family requested that nursing assistants document in a log the times when R262 is repositioned and the family does keep close eye on the times of repositioning. She indicated that generally the family is pleasant to all the nursing staff. Registered nurse (RN)-C was interviewed on 10/18/12, at 8:30 a.m. and verified R262's husband had been very angry at her earlier in the day. She indicated that he was concerned about the resident's breathing. She reported she	21470		

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21470	Continued From page 18 assessed the resident and did not find the resident in any respiratory distress but did superficial suctioning of the tracheostomy with minimal return. She also reported that husband was upset about blood he observed on R262's sleeve and RN-C thought "he was afraid of blood." She indicated that generally R262's husband and family are generally cooperative and was surprised by his reaction earlier today. The DON was interviewed on 10/18/12, at 12:30 p.m. and verified she was aware of family's concerns. She reported R262's had been given a third Mantoux, which was not needed as staff had forgotten to transcribe the administration of the Mantoux to the immunization record. She also reported that she had completed a chart audit of the resident's condition on 10/14/12, and had determined R262 was declining. She then contacted R262's physician and expressed concern regarding potential skin breakdown and requested the physician insert a Foley catheter. The DON indicated she was of aware of the family's decision to refuse medication and lab testing at times, which she respected. The DON did not make any indication however, there were conversations held with the family in regards to the family's expectations of care and treatment for R262. An interview with the social services supervisor (SW)-A was completed on 10/19/12, at 11:04 a.m. She reported not being aware of R262's family concerns, even though she attended "stand up" meetings every morning and "triage meetings" daily, where reports of residents conditions are discussed. She also reported that she will occasionally meet with R262's husband, but the discussions were generally very superficial, (discuss weather etc.) She reported	21470		

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21470	Continued From page 19 she had talked to R262's husband on 10/19/12, and the husband had told her that family expected R262 to leave the facility walking. She indicated R262's family seemed to be having difficulty accepting the probably this would not happen and potentially R262 was terminal. She verified social services were not meeting with the family on a regular basis to discuss her medical condition or offered additional services to the family to aid them with the acceptance of R262 condition and prognosis. She also reported social services had not been involved with advocating for the family's requests with nursing staff and addressing the cultural issues presented. SUGGESTED METHOD FOR CORRECTION: The Social Services Supervisor could review policies and procedures to ensure that residents are assisted with maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21470		

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21520	Continued From page 20	21520		
21520	MN Rule 4658.1300 Subp. 1-4 Medications and Pharmacy Services; Definition Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4. Subp. 2. Schedule II drugs. "Schedule II drugs" means drugs with a high potential for abuse that have established medical uses as defined in Minnesota Statutes, section 152.02, subdivision 3. Subp. 3. Pharmacy services. "Pharmacy services" means services to ensure the accurate acquiring, receiving, and administering of all drugs to meet the needs of each resident. Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmaceutical services were secured, including routine medications and biologicals as ordered for 6 of 9 residents (R292, R161, R284, R51, R30 and R270), reviewed for missed medication doses due to medications not being available for administration. Findings include: Medication was not administered timely for R292 due to the medication being unavailable. R292 was admitted to the facility on 9/28/12, with diagnoses including closed fractures of the	21520		

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21520	Continued From page 21 patella and upper humerus. Physician orders dated 9/28/12, revealed R292 was to receive oxycodone/ acetaminophen (Percocet) 5-325 mg, one to two tablets by mouth every four hours as needed for moderate to severe pain. On 10/17/12, at 12:25 p.m., R292 was observed to approach licensed practical nurse (LPN)-R and stated, "Have you got my Percocet yet?" When LPN-R replied, "No," R292 was noted to sigh loudly and shake her head. R292 then stated that this was the third time that the facility had run out of her medication. LPN-R was asked about the facility's process for ordering medication from the pharmacy and whether they had difficulty getting medications in time to administer them as ordered. LPN-R verified the facility had run out of medications "at times" and had not received resident medications timely, to the point that residents had to miss doses of medications ordered by their physician. LPN-R reported that the facility's process for refilling medication was to remove the label from the medication "when it was getting close to running out." The label was then to be placed onto a sheet of paper and faxed to the pharmacy. LPN-R reported that if a medication was needed right away, the nurses were to call the pharmacy and request a stat order of the medication. LPN-R reported that she had typically been able to receive a stat medication order from the pharmacy within two hours of the request. LPN-R reported that there had been occasions when she had faxed a medication label to the pharmacy for refill and when she arrived for her next shift "a couple of days later," the medication had still not arrived and the resident had missed several doses as a result of the medication not being available.	21520		

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21520	Continued From page 22 LPN-R reported that when she encountered these situations, she would call in a stat order to the pharmacy and received the medication within two hours. LPN-R reported that she was not sure why the delay was occurring, other than to guess that the re-fill date on the label may have indicated to the pharmacy that the medication did not need to be sent until that date. LPN-R indicated that she had reported this problem with medication refills to the unit care manager (CM) -E. LPN-R verified that she was awaiting a stat order for R292's Percocet. During an interview on 10/17/12, at 12:40 p.m., R292 reported that she last received her Percocet at 7:00 a.m. and had requested another dose at 11:00 a.m., when she was told the facility was out of the medication. R292 identified her pain as an eight on a scale of one to 10. R292 stated, "It's awful... throbbing... aching... horrible." R292 described her pain as from her left shoulder/ neck area, down her arm and into her hand. She also reported pain in her right knee to quadriceps. R292 stated, "It is unacceptable," having to wait for her pain medication. Review of R292's Pain Flow Sheet from 10/1/12 to 10/17/12, revealed consistent pain ratings of 8 to 10 (on a scale of 10) prior to administration of as needed Percocet and pain ratings of 1 to 4 post administration of as needed Percocet. Review of medication administration record (MAR) for 10/1/12 to 10/17/12, revealed two tablets of Percocet 5-325 mg were last administered to R292 at 7:30 a.m. on 10/17/12. Review of progress note for R292, signed by LPN-R on 10/17/12, at 3:00 p.m. read, "At about 1030 [10:30 a.m.] resident asked for more pain	21520		

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21520	Continued From page 23 pills, rates pain as 8/10, at the time pills were called to pharmacy to get them to come out on 1st run, hopefully stat. Resident was very upset when writer told her that 'the pills were on the way but could take up to 4 [four] hours to get here.' Resident [at] 12 Noon [12:00 p.m.] re-approached writer asking if pills have arrived yet... resident was still very upset, writer offered Tylenol to be given, but resident denied. At 1400 [2:00 p.m.] pain meds arrived, given 2, relief noted at 1500 [3:00 p.m.]." Six medication doses were missed for R161 due to the medication not being available for administration. R161 diagnoses included hypopituitarism (decreased secretion of hormones normally produced by the pituitary gland). Physician orders dated 9/29/12, revealed R161 was to receive an injection of genotropin, 0.4 mg daily for hypopituitarism. Genotropin was indicated for replacement of growth hormone. Review of the MAR for 9/1/12 to 9/30/12, revealed R161 was not administered the injection of genotropin as scheduled, at 8:00 a.m. on 9/1/12, 9/2/12, 9/3/12, 9/4/12, 9/5/12 and 9/6/12. Review of Medication Error Report dated 10/17/12, revealed the medication genotropin was not administered to R161 from 9/1/12 through 9/6/12, due to a delay in insurance coverage. No ill effects were noted as a result of these errors. Medication was not administered timely for R284 due to the medication being unavailable.	21520		

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21520	Continued From page 24 R284 diagnoses included end stage renal disease and chronic anemia. The admission minimum data set (MDS) dated 9/20/12, revealed R284 was cognitively intact and received dialysis while a resident within the facility. Physician orders dated 9/27/12, identified R284 was to receive calcium acetate (PhosLo), 667 mg (milligrams), four capsules by mouth three times daily with meals and at bedtime for end stage renal disease. PhosLo was indicated for control of hyperphosphatemia (a well-recognized risk factor for cardiovascular mortality in dialysis patients). On 10/17/12, at 12:10 p.m., R284 reported that the facility nurses were refusing to administer a medication that he needed in order to eat his lunch. R284 reported, "They're telling me they don't have the medication... that they're out of it." R284 reported that he needed the medication to help break down his food and he had to take the medication before he ate or he would get sick. R284 reported that lunch was scheduled to be served in the facility at 11:30 a.m. and he had to wait to eat because he had not received this medication. During interview on 10/17/12, at 12:15 p.m. LPN-R verified that she was going to administer R284's PhosLo at 11:00 a.m., but when she looked in her medication cart, she noticed that there were no PhosLo pills left in R284's medication bubble pack (pre-set up/ pre-packaged medication punch card). LPN-R reported that once she noticed there were no PhosLo pills left for R284, she called the pharmacy to request a stat delivery of the	21520		

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21520	Continued From page 25 medication. LPN-R reported that the pharmacy had since called back and instructed her to check the medication cart to see if the same medication was available in the facility's stock medication bottles. LPN-R reported she had located the medication and was prepared to administer the medication to R284. During observation on 10/17/12, at 12:30 p.m., LPN-R was noted to administer R284's PhosLo in the second floor dining room. R284 was then served his lunch, an hour after other residents had eaten. One medication dose was missed for R51 due to the medication not being available for administration. R51 diagnoses included gastrointestinal hemorrhage, heart disease and a history of superior mesenteric vein (SMV) thrombosis. Physician orders dated 9/29/12, revealed R 51 was to receive an injection of Fragmin 5,000 units per 0.2 ml (milliliters) daily, until fully ambulatory. Fragmin was indicated for deep vein thrombosis (DVT) prophylaxis. Review of the MAR for 10/1/12 to 10/17/12, revealed Fragmin was not administered to R51 on 10/9/12, with a note indicating the medication was not in stock. Review of Medication Error Report dated 10/17/12, revealed the medication Fragmin, scheduled for administration on 10/9/12, at 8:00 a.m. was missed. Reason for the error was noted as, "Not here ordered." The report noted the medication arrived from the pharmacy at 4:58 p.m. No complications arose from this	21520		

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21520	Continued From page 26 medication error. R51's physician was notified of this missed dose on 10/17/12, at 12:00 p.m. Medication was not offered to R30 for timely administration due to the medication not being available. R30 diagnoses included paranoid schizophrenia. Physician orders dated 10/3/12, revealed R30 was to receive an injection of fluphenazine decanoate (Prolixin Decanoate) 50 mg every two weeks (Monday overnight shift) for schizophrenia. Prolixin Decanoate was indicated as a long-acting antipsychotic for individuals with chronic schizophrenia. Review of the MAR for 10/1/12 to 10/17/12, revealed R30 was not administered the injection of Prolixin Decanoate as scheduled during the night shift on 10/9/12. Review of Medication Error Report dated 10/9/12, revealed the medication Prolixin Decanoate was not offered to R30 the morning of 10/9/12. The reason for error was noted as, "Not available for administration." No adverse reactions were noted from this error. R30's physician was promptly notified of this medication error. Review of progress notes for R30 from 10/9/12 through 10/11/12, revealed the Prolixin Decanoate was not administered on 10/9/12, but was reordered on 10/9/12. Subsequent notes indicated that once the medication was delivered by the pharmacy, R30 refused the injection multiple times successful administration on 10/11/12. Medication doses were missed for R270 due to	21520		

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21520	Continued From page 27 the medication not being available for administration. R270 diagnoses included depression. Physician orders dated 9/1/12 revealed R270 was to receive citalopram (Celexa) 20 mg daily for depression, via her feeding tube. Review of the MAR for 10/1/12 through 10/17/12, revealed R270 was not administered her daily 20 mg dose of Celexa on 10/14/12 and 10/17/12. The MAR also indicated that only a half dose was administered on 10/16/12. Review of Medication Error Report dated 10/17/12, revealed the medication Celexa was not administered as scheduled at 8:00 a.m. on 10/14/12 and 10/17/12. The report also indicated that only a half dose was administered on 10/16/12. The report noted that precautions taken to prevent similar errors included educating nurses to report missing doses. R270's physician was notified of these missed doses on 10/17/12, at 6:00 p.m. During interview on 10/17/12, at 12:50 p.m., CM-E verified the facility's process for refilling prescriptions from the pharmacy. She reported that she had taught the nurses to request refills at least 24 hours ahead of the time they were needed, by removing the label from the medication and faxing the label to the pharmacy. She reported she had also trained the nurses to call the pharmacy for a stat order if the ordered time for administration was drawing near. CM-E reported, to her knowledge, the longest the facility had to wait for a medication from the pharmacy was 48 hours. She denied being informed of any residents who had missed doses of medications	21520		

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21520	Continued From page 28 due to medications not being available. During follow-up interview on 10/17/12, at 1:25 p.m., LPN-R again verified that she had reported concerns of residents who had missed doses of medications ordered, due to the medications not being available. LPN-R verified she had reported this concern to CM-E. During interview on 10/18/12, at 5:21 p.m., director of nursing (DON) verified the facility was having "significant" issues with their contracted pharmacy. DON reported the pharmacy had not been allowing for automatic refills and was solely relying on facility staff to request the medication for the order to be filled. DON reported that the facility currently had a contract with the pharmacy to fill medications regardless of eligibility for insurance coverage for seven days (to be paid for by the facility) to ensure residents were receiving the medications they needed. DON reported that the pharmacy had not been honoring that contract. DON stated, "If there is no payer, no authorized place to bill, they will not fill the prescription," despite the facilities contracted agreement to cover seven days of medications in those circumstances. DON also indicated the facility was also having difficulty with the pharmacy "dropping orders" that were ordered to be on-going. DON reported that medication errors due to medications being unavailable for administration had been a more recent concern. She reported that the facility had identified some medication errors related to this concern prior to survey entrance, but was not aware of missed doses that nursing staff had not reported to her, until the time of the survey and all MARs were audited for missed doses due to medications being unavailable for administration. DON reported it was her expectation that if a	21520		

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21520	Continued From page 29 medication was not available for administration, the nurse would circle the dose missed on the MAR, write on the back of the MAR that the medication was not available and notify their supervisor so follow-up could occur and the physician could be notified. The facility's Medication Administration Procedure revised 7/10, instructed licensed nurses and/ or medication assistant's to indicate the reason for any dose omission in progress notes or on the back of the MAR. The policy noted, "It is not acceptable to omit a dose by indicating 'NA' for medication not available from pharmacy. Remove a dose from Back-up Supply/ Emergency Kit or contact pharmacy or on-call pharmacist and request medication to be sent ASAP [as soon as possible]. If the medication is not available, contact the physician for further orders." Suggested Method of Correction: The administrator or designee could review the pharmacy policy and revise systems to improve the delivery of medications for each resident and ensuring that expired medications are not stored at the facility. Provide training for pharmacy staff and facility staff regarding these systems. Monitor the medication system to assure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21520		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual,	21530		

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21530	Continued From page 30 Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify, assess and monitor clinical indications to evaluate the	21530		

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21530	Continued From page 31 effectiveness and continued use of medications for 1 of 10 residents (R31) whose medication regimen was reviewed. Findings include: Resident (R31) was receiving xanax (used to treat anxiety and panic disorders) 0.5 milligrams (mg) three times daily as needed (PRN) for anxiety since 03/02/12, and trazodone (antidepressant) 25 mg daily at bedtime as needed for sleep since 01/26/10. Both medications (xanax and trazodone) were administered without adequate monitoring. R31 was admitted to the facility on 02/14/2001, with diagnoses that included panic disorder, insomnia, schizophrenia and depression. An annual Minimum Data Set (MDS) assessment, dated 07/03/12, identified R31 as cognitively intact with no behavioral issues and multiple mood indicators (examples included: feeling down, little interest in activities, feeling tired and bad about self) were coded on the MDS. The current physician's order, dated 10/09/12, indicated R31 had been receiving xanax 0.5 mg three times daily as needed (PRN) for anxiety and trazodone 25 mg at bedtime PRN for sleep. In addition, R31 received scheduled doses of xanax 0.5 mg for anxiety every morning and trazodone 25 mg twice a day for anxiety. Although the facility provided the psychiatrist's and licensed social worker visits to R31 (twice in February, once in April, four times in May, once in July and once in August 2012), the documentation lacked a comprehensive evaluation of R31's specific anxious behaviors,	21530		

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21530	Continued From page 32 sleep and awake patterns and review of facility staff's documentation on R31's specific panic/anxious episodes to justify the use of PRN xanax and trazodone medications. Medication Administration Records (MAR) from July 2012 to present were reviewed and indicated R31 used PRN xanax 28 times in July, 24 times in August, 21 times in September, and 11 times in October 2012. Trazodone PRN was used four times in September 2012 and one time in October 2012. The medical record lacked appropriate monitoring of these medications, including specific anxious/panic behaviors exhibited by R31, any non-pharmacological interventions attempted and outcome of these interventions. In addition, the facility did not monitor all appropriate side-effects associated with use of these medications, for example orthostatic blood pressures. A "7 day sleep diary," record indicated staff monitored only three nights in May (5/11, 5/12, 5/13/12) of R31's sleep pattern, otherwise, there was no evidence the facility staff monitored R31's sleep/awake patterns to justify the use of Trazodone for sleep. On 10/18/12, at 1:00 p.m. and 1:45 p.m., Unit Manager, Registered Nurse, RN(B) stated R31 had diagnosis of anxiety, panic attacks and paranoid schizophrenia for many years and had been receiving these medications for a number of years. RN-B indicated the resident did not exhibit explosive behaviors, rather would alert the nursing staff on how she felt and would request for PRN medications. RN-B added, the nursing staff documented in the progress notes and in care tracker (computerized documentation) when administered PRN medications. After reviewing the progress notes and the care tracker data, RN-B verified that appropriate monitoring	21530		

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21530	Continued From page 33 documentation, including side-effect monitoring, was lacking for R31. Facility's "Psychoactive Medication" policy/procedures, revised on October 2008, directed staff to monitor and document regularly on side effects, non-drug approaches, resident responses to interventions, and target symptoms. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State	21535		

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21535	Continued From page 34 Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the Consultant Pharmacist failed to ensure that 1 of 10 residents (R31) whose medications were reviewed included adequate monitoring of efficacy was in place. Findings include: Resident (R31) was receiving xanax (used to treat anxiety and panic disorders) 0.5 milligrams (mg) three times daily as needed (PRN) for anxiety since 03/02/12, and trazodone (antidepressant) 25 mg daily at bedtime as needed for sleep since 01/26/10. Both medications (xanax and trazodone) were administered without adequate monitoring. R31 was admitted to the facility on 02/14/2001 with diagnosis that included panic disorder, insomnia, schizophrenia and depression. An annual Minimum Data Set (MDS) assessment, dated 07/03/12, identified R31 as cognitively intact with no behavioral issues and multiple mood indicators (feeling down, little interest in activities, feeling tired and bad about self) were coded on the MDS.	21535		

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21535	Continued From page 35 Current physician's order, dated 10/09/12, indicated R31 had been receiving xanax 0.5 mg three times daily as needed (PRN) for anxiety and trazodone 25 mg at bedtime PRN for sleep. In addition, R31 received scheduled doses of xanax 0.5 mg for anxiety every morning and trazodone 25 mg twice a day for anxiety. Although the facility provided the psychiatrist's and licensed social worker visits to R31 (twice in February, once in April, four times in May, once in July and once in August 2012), the documentation lacked a comprehensive evaluation of R31's specific anxious behaviors, sleep and awake patterns and review of facility staff's documentation on R31's specific panic/anxious episodes to justify the use of PRN xanax and trazodone medications. Medication Administration Records (MAR) from July 2012 to present were reviewed and indicated R31 used PRN xanax 28 times in July, 24 times in August, 21 times in September, 11 times in October 2012. Trazodone PRN was used 4 times in September 2012 and 1 time in October 2012. The medical record lacked appropriate monitoring of these medications, including specific anxious/panic behaviors exhibited by R31, any non-pharmacological interventions attempted and outcome of these interventions. In addition, the facility did not monitor all appropriate side-effects associated with use of these medications, for example orthostatic blood pressures. A "7 day sleep diary," record indicated staff monitored four nights in May (5/11, 5/12, 5/13, 5/14/12) of R31's sleep pattern, otherwise, there was no evidence the facility staff monitored R31's sleep/awake patterns to justify the use of Trazodone for sleep. On 10/18/12, at 1:00 p.m. and 1:45 p.m., Unit	21535		

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21535	Continued From page 36 Manager, Registered Nurse, RN-B stated R31 had diagnosis of anxiety, panic attacks and paranoid schizophrenia for many years and had been receiving these medications for a number of years. RN-B indicated that the resident did not exhibit explosive behaviors, rather would alert the nursing staff on how she felt and would request for PRN medications. RN-B added, the nursing staff documented in the progress notes and in care tracker (computerized documentation) when administered PRN medications. After reviewing the progress notes and the care tracker data, RN-B verified that appropriate monitoring documentation, including side-effect monitoring, was lacking for R31. On 10/18/12, at 4:00 p.m. and 4:30 p.m., the consulting pharmacist, after reviewing R31's medical record, verified the nursing staff needed to monitor and document on the use of psychotropic medications. The consulting pharmacist indicated the sleep assessment and monitoring were lacking for R31. The consulting pharmacist indicated that these issues needed to be brought to the attention of director of nursing and physician. Facility's "Psychoactive Medication" policy/procedures, revised on October 2008, directed staff to monitor and document regularly on side effects, non-drug approaches, resident responses to interventions, and target symptoms. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements.	21535		

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21535	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure open medications were dated when open and expired medications were not administered for one of seven medication carts reviewed for medication storage. The facility also failed to keep controlled substances locked and accessible to authorized personnel only and stored medications with food items for one of five refrigerators that were reviewed for medication storage. Findings include: On 10/15/12, at 1:45 p.m., a Byetta injectable pen (a prescription medicine that may improve blood sugar (glucose) control in adults with type 2 diabetes mellitus), was found in the first floor refrigerator in the medication storage room and was open; however, there was no open date on the medication. A review of the Amylin Pharmaceuticals, Inc. recommended storage guidelines indicated the Byetta Pen was to be used for only 30 days. After 30 days, the pen should be discarded even if there was some medicine left in the pen. Registered nurse (RN)-A verified no open date was on the pen and that it should have been dated when opened.	21620		

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21620	Continued From page 38 During an observation of the first floor medication cart on 10/15/12, at 2:00 p.m., a vial of Heparin (a blood thinning medication used to prevent blood clots) was found in the top drawer. The multi-use vial had an expiration date of September 2012. The heparin had last been administered that morning on 10/15/12, at 8:00 a.m., 15 days past the expiration date. During continued review of the first floor medication cart, two dispensers of Advair Diskus (an inhaler used to treat asthma and chronic obstructive pulmonary disease) were found in the bottom drawer opened; however, the medication opened date labels were blank. RN-A stated Advair inhalers were to be dated when opened and each nurse was responsible for checking the medications for expiration and opened dates prior to administration. The GlaxoSmithKline (manufacturer of Advair) recommended storage guidelines were to discard Adviar Diskus one month after removal from the foil pouch, or after the dose indicator reads "0", whichever comes first. Upon inspection of the unlocked refrigerator on the third floor dementia unit on 10/15/12, at 5:23 p.m., a multi dose vial of Ativan (a schedule IV controlled substance anti-anxiety medication) was found to be stored on the top shelf of the door. Also in the door was a multi dose vial of Tubresol (a medication used to aid in the diagnosis of a tuberculosis infection) which did not have an open date. Licensed practical nurse (LPN)-A immediately removed the vial of Ativan and placed it in the locked refrigerator in the third floor locked medication room. LPN-A stated the Tubresol needed to be thrown out because it had	21620		

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21620	Continued From page 39 been opened and stored in a refrigerator that was used for food storage. LPN-A further stated the Ativan should not have been stored in the unlocked refrigerator. Review of the facility's Storage and Expiration Date of Medications, Biologicals, Syringes and Needles policy dated 5/10/10, revealed food is not to be stored in the refrigerator, freezer, or general storage areas where medication and biologicals are stored. The policy also indicated medications that have an expired date on the label should be stored separate from other medications until destroyed or returned to the supplier. Furthermore, the policy indicated the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications and that facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Finally, the policy indicated the facility should ensure Schedule II-V controlled substances are only accessible to licensed nursing, pharmacy and medical personnel designated by facility. Review of the medication administration policy dated 7/10 revealed the licensed nurse and/or medication assistant were to verify the correct medication and expiration date prior to administration. During interview on 10/29/12 at 12:30 p.m., consulting pharmacist confirmed the Advair Diskus, Byetta and Tubresol medications should have been dated when opened. Consulting pharmacist also verified the expired vial of Heparin should have been discarded and should not have still been in use past the expiration date.	21620		

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21620	Continued From page 40 SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are labeled and stored appropriately. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Thirty (30) days	21620		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request	21800		

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21800	Continued From page 41 to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate liability and appeal rights notice upon termination of Medicare Part A benefits for 1 of 3 residents (R128) reviewed in the sample for liability notices and beneficiary appeal rights review. Findings include: R128 was admitted to the facility on 4/6/12, with diagnoses that included an above the knee amputation. R128 was discharged to home on 5/8/12. A review of R128's physical therapy (PT) Assistant Progress Update notes, dated 5/4/12, revealed, "The pt [patient] may D/C [discharge] home with Daughter affective 5/8/12.". The PT Progress Report and Discharge Summary, dated 5/7/12, indicated R128 would be discharged from physical therapy on 5/7/12, with benefit days remaining. R128's medical record revealed the facility had not provided the Centers for Medicare and Medicaid Services (CMS) form 10123 to inform R128 or his legal representative of his right to an expedited review of service termination following termination of all Medicare Part A services for coverage reasons. During interview on 10/18/12, at 2:25 p.m., the minimum data set (MDS) coordinator verified she was responsible for providing liability notices and appeal rights for Medicare beneficiaries within the	21800		

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21800	Continued From page 42 facility. MDS coordinator verified it was her understanding and the facility's practice that denial and appeal rights notices were not required for residents who remained on Medicare Part A from admission to discharge and discharged to home. MDS coordinator verified the CMS form 10123 had not been provided to R128 or his legal representative. On 10/18/12, at 3:00 p.m., MDS coordinator reported that R128 would have remained eligible for Medicare Part A services, had he chosen to remain in the facility, based on restorative and skilled nursing needs. The facility's Expedited Review, Notice of Medicare Non-Coverage Procedure revised 4/12 identified the facility would notify Medicare beneficiaries of its decision to terminate Medicare Part A, no later than two days before coverage of services was terminated. SUGGESTED METHOD OF CORRECTION: The director of social services or designee could educate all appropriate staff members on the process of the required admission paperwork. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee TIME PERIOD FOR CORRECTION: Thirty (21) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		

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21805	Continued From page 43 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure privacy was provided during personal cares for 1 of 3 residents (R130) reviewed in the sample for privacy. Findings include: R130 was re-admitted on 05/03/12, with diagnoses that included stage IV chronic kidney disease and peripheral vascular disease. The 30 day Minimum Data Set (MDS) assessment, dated 08/15/12, indicated R130 was alert and oriented and was cognitively intact. In addition, it also indicated R130 required minimal assistance of encouragement, supervision and cues from staff for personal hygiene and dressing needs. R130 required one person physical assist for walking in his room. On 10/17/12, at 1:30 p.m., R130 voiced concerns regarding nursing staff not providing him privacy during morning cares. R130 indicated that he preferred to wash himself in the mornings, at his bedside, to sustain his independence and staff would leave his room door wide open for people who passed by to view him naked. R130 expressed his frustrations and said no one would want others to see them naked and that despite his multiple requests to have his room door shut, the staff did not do it. On 10/17/12, at 2:14 p.m. Unit Manager, Registered Nurse, RN (B) verified that nursing assistants (NAR) did not always shut residents' room doors and needed reminders when RN (B) would conduct audits of cares. RN(B) indicated that NARs may need further education on	21805		

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21805	Continued From page 44 importance of ensuring privacy during cares. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents rights are provided in regards to privacy. The director of nursing or designee could educate all appropriate staff members policy and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		