CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 53FD

Facility ID: 00112

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

MEDICARE/MEDICAID PROVIDER NO. (L1) 245186 2.STATE VENDOR OR MEDICAID NO. (L2) 286742700	3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN VALLEY REHABILITA (L4) 7505 COUNTRY CLUB DRIVE (L5) GOLDEN VALLEY, MN	L3) GOLDEN VALLEY REHABILITATION AND CARE CENTER L4) 7505 COUNTRY CLUB DRIVE			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRI	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 12/5/2012 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 IMR 04 SNF 08 OPT/SP 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 164 (L18 13. Total Certified Beds 164 (L17 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 164 (L37) (L38) (L38)	B. Not in Compliance with Program Requirements and/or Applied Waivers: F ICF IMR	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director		
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LTC CANCELLATION DATE):				
See Attached Remarks					
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	APPROVAL Date:		
Sarah Grebenc, Unit Supervisor	01/11/2013 (L19)	Nicole Steege, Progra	am Specialist 01/11/2013 (L20)		
			(L20)		
	(L19) BE COMPLETED BY HCFA REGION. 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	AL OFFICE OR SINGLE ST. 21. 1. Statement of Finan	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L19) BE COMPLETED BY HCFA REGION. 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	AL OFFICE OR SINGLE ST. 21. 1. Statement of Finar 2. Ownership/Contro	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE 23. LTC AGRI	(L19) BE COMPLETED BY HCFA REGION. 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) : (L30) INVOLUNTARY 05-Fail to Meet Health/Safety		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible 23. LTC AGRI OF PARTICIPATION BEGINN. 08/31/1973 (L24) (L41)	20. COMPLETED BY HCFA REGION. 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 24. LTC AGREEMENT NG DATE (L25)	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ont 06-Fail to Meet Agreement		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE	DEFINITION OF THE PROPERTY OF	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety of the method of t		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE OF PARTICIPATION 08/31/1973 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERN A. Suspe	20. COMPLETED BY HCFA REGION. 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 24. LTC AGREEMENT NG DATE (L25)	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ont 06-Fail to Meet Agreement		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE OF PARTICIPATION 08/31/1973 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERN A. Suspe	DEFINITIONS 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 24. LTC AGREEMENT NG DATE (L25) ATIVE SANCTIONS sion of Admissions: (L44) Suspension Date:	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety of the Meet Agreement OTHER 07-Provider Status Change		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE	DEFINITION (L44) BE COMPLETED BY HCFA REGION (L45) 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 24. LTC AGREEMENT ENDING DATE (L25) ATIVE SANCTIONS sion of Admissions: (L44) Suspension Date: (L45)	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety of the Meet Agreement OTHER 07-Provider Status Change		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible 23. LTC AGRI OF PARTICIPATION BEGINN. 08/31/1973 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERN A. Suspe (L27) B. Rescince	EMENT 24. LTC AGREEMENT NG DATE ENDING DATE (L25) ATIVE SANCTIONS sion of Admissions: (L44) Suspension Date: (L45) 29. INTERMEDIARY/CARRIER NO. 00450	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L20) ATE AGENCY Icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety of the Meet Agreement OTHER 07-Provider Status Change		
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE	DEFINITION (L45) 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 24. LTC AGREEMENT NG DATE (L25) ATIVE SANCTIONS sion of Admissions: (L44) Suspension Date: (L45) 29. INTERMEDIARY/CARRIER NO. 00450 (L31)	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L20) ATE AGENCY Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety of-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00112

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

Page 2 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.



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:

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, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Division of Compliance Monitoring

Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



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.

Santo Drebenc

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building		(Y3) Date of Revisit	
	245186	B. Wing			
Name of Facility			Street Address, City, State, Zip Code		
GOLDEN VALLEY REHABILITATION AND CARE		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
			Correction Completed						Correction Completed					Correction Completed
ID Prefix	F0156		11/27/2012		ID Prefix	F0241			11/27/2012		ID Prefix	F0250		11/27/2012
ū	483.10(b)(5) - (10), 483.10(k	p)(1)		•	483.15(a)				•	483.15(g)(1)		
LSC					LSC						LSC			
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 11/27/2012		ID Prefix Reg. # LSC	F0312			Correction Completed 11/27/2012			483.25(g)(2)		Correction Completed 11/27/2012
				-	LSC									_
ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 11/27/2012		ID Prefix Reg. # LSC	<u>F0371</u> 483.35(i			Correction Completed 11/27/2012		ID Prefix Reg. # LSC	483.60(a),(b)		Correction Completed 11/27/2012
ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 11/27/2012		ID Prefix Reg. # LSC		b), (d), (e)		Correction Completed 11/27/2012					
ID Prefix Reg. # LSC					ID Prefix Reg. # LSC									
Reviewed By		Reviewed E	-	Da 1	te: /11/13	:	Signature of	Surve	yor: 28589	9			Date:	12/5/12
Reviewed By	, ——	Reviewed E	Зу	Da	te:	:	Signature of	Surve	yor:				Date:	
Followup to	Survey Comple 10/19	eted on: 0/2012		_		1		-				a Summary of to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 53FD

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

PART	I - TO BE COMP	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00112	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245186 2.STATE VENDOR OR MEDICAID NO. (L2) 286742700	3. NAME AND AL (L3) GOLDEN V (L4) 7505 COUN' (L5) GOLDEN V	ALLEY REHA TRY CLUB DE	BILITATI	ON AND CARE CENTER (L6) 55427	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 10/19/2012 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 IMR 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION From (a): (b): To (b): 12. Total Facility Beds 175 (L18) 13. Total Certified Beds 175 (L17)	Complian1		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 175	ICF	IMR		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICAL See Attached Remarks	(L42) BLE SHOW LTC CANCE	(L43) ELLATION DATE	Ξ):			
17. SURVEYOR SIGNATURE Marilyn Kaelke, HFE-NEII	Date :	11/19/2012	7.10	18. STATE SURVEY AGENCY Nicole Steege, Progr		
PART II - TO	BE COMPLETED	BY HCFA R	(L19) EGIONA	L OFFICE OR SINGLE S	·	L20)
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COM	MPLIANCE WITH GHTS ACT:		21. 1. Statement of Fin	nancial Solvency (HCFA-2572) trol Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE 23. LTC AGREI OF PARTICIPATION BEGINNIN 08/31/1973 (L24) (L41)		24. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburser	00 INVOLUNTARY 05-Fail to Meet Health/Safety	
25. LTC EXTENSION DATE: 27. ALTERNA A. Suspens	TIVE SANCTIONS ion of Admissions: Suspension Date:	(L44) (L45)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/0		(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION	OF APPROVAL E	DATE (L33)	DETERMINATION APP	PROVAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00112

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

Page 2

Provider Number: 24-5186

Item 16 Continuation for CMS-1539

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.



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:

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Santo Drebene

Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

NOV 1 6 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/02/2012

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 245186 10/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARE CENTER GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Disclaimer For Plan of Correction F 000 INITIAL COMMENTS F 000 Golden Valley Rehabilitation and Care Center objects to the allegation of non-The facility's plan of correction (POC) will serve compliance. Submission of this response as your allegation of compliance upon the and Plan of Correction is not a legal Department's acceptance. Your signature at the admission that a deficiency exists or, that bottom of the first page of the CMS-2567 form will this Statement of Deficiency was be used as verification of compliance. correctly cited, and is also not to be 2012 construed as an admission against Upon receipt of an acceptable POC an on-site WED interest by the facility, the Administrator revisit of your facility may be conducted to 391 or any employees, agents, or other validate that substantial compliance with the individuals who draft or may be regulations has been attained in accordance with discussed in the Response and Plan of vour verification. Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or A standard recertification survey was conducted agreement of any kind by the facility of and a complaint investigation was also completed the truth of any facts alleged or the at the time of the standard survey. correctness of any conclusions set forth in this allegation by the survey agency. An investigation of complaint H5186196 and Golden Valley Rehabilitation and Care H5186195 were completed. The complaint is not Center respectfully makes its allegation substantiated. of compliance on all areas and has F 156 F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF written these Plans of Correction to RIGHTS, RULES, SERVICES, CHARGES SS=D constitute the allegation. The Center is alleging compliance on November 27, The facility must inform the resident both orally 2012. and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and F156 responsibilities during the stay in the facility. The 1.) The identified resident has been facility must also provide the resident with the discharged from the facility per notice (if any) of the State developed under his choice. §1919(e)(6) of the Act. Such notification must be 2.) Effective August 2012, made prior to or upon admission and during the GVRCC has issued Notice of resident's stay. Receipt of such information, and Medicare Non-Coverage to all any amendments to it, must be acknowledged in residents upon d/c from facility writing. if they were covered by Medicare A benefits.

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

The facility must inform each resident who is

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.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	E CONSTRUCTION	(X3) DATE COMPI	
		245186	B. WI	1G		10/	C 19/2012 ^{(⊜}
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP COI 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427	······································	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 156	entitled to Medicaid of admission to the resident becomes a items and services facility services und which the resident to other items and ser and for which the resident the amount of charginform each resider the items and servic (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargunder Medicare or The facility must fur legal rights which in A description of the personal funds, und section; A description of the for establishing eliging the right to request 1924(c) which deternon-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the services in the resident of the services and the cost of the resident of the cost of the cost of the resident of the reside	benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing fer the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and in when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or esion, and periodically during of services available in the est for those services, est for services not covered by the facility's per diem rate. This is a written description of ecludes: The manner of protecting der paragraph (c) of this requirements and procedures ibility for Medicaid, including an assessment under section remines the extent of a couple's ces at the time of and attributes to the community eshare of resources which end available for payment the institutionalized spouse's or her process of spending	F	156	 3.) Education complete and procedure with BOM, SS, and CRC 4.) Weekly audits of redischarged receiving their Medicare A best. 5.) Audit results will be by facility QA commodinator (CRC) responsible for commodition for commodition of the commodities of the commodities of the commodities of the commodities of	NHA, c. sidents g utilizing mefit. e reviewed mittee. ment is	11/27/12

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	COMPLI	ETED
		245186	B. WI	VG	*************************************	1	C 9/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	A posting of names numbers of all pertitions of all pertitions of all pertitions as the agency, the State litions of advocacy network, unit; and a stateme complaint with the sagency concerning misappropriation of facility, and non-condirectives requirem. The facility must conspectified in subpartice to maintaining procedures regarding requirements include a written information, formulate an includes a written option, formulate an includes a written option, formulate an includes a written opticable State law. The facility must infiname, specialty, an physician responsition. The facility must prowritten information, applicants for admininformation about he Medicare and Me	, addresses, and telephone nent State client advocacy State survey and certification censure office, the State im, the protection and and the Medicaid fraud control int that the resident may file a State survey and certification resident abuse, neglect, and resident property in the impliance with the advance ents. I of part 489 of this chapter ing written policies and ing advance directives. These is provisions to inform and imation to all adult residents it to accept or refuse medical int and, at the individual's in advance directive. This in advance directives and interesting in advance directives and interesting in advance directives and interesting interesting in advance directives and interesting in	F	156			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE		
		245186	B. Wil	√G	·		C 9/201:	2
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		78	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE		(5) LETION ATE
F 156	This REQUIREMENT by: Based on interview facility failed to provappeal rights notice Part A benefits for reviewed in the san beneficiary appeal of Findings include: R128 was admitted diagnoses that incluamputation. R128 5/8/12. A review of R128's Assistant Progress revealed, "The pt [phome with Daughte Progress Report and 5/7/12, indicated R2 physical therapy on remaining. R128's medical recont provided the Composite of the Comp	NT is not met as evidenced and document review, the vide appropriate liability and e upon termination of Medicare of 3 residents (R128) apple for liability notices and	F	156				CASSING THE PROPERTY OF THE PR

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		245186	B. WIN	√IG	-		0 9/2012
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7!	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		14 (3 11 (3) 1 (3)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 156	from admission to chome. MDS coordinator representative. On coordinator reporter remained eligible for had he chosen to restorative and skill. The facility's Exped Medicare Non-Coveridentified the facility beneficiaries of its of Part A, no later that services was terminated and the chosen of the common of th	discharge and discharged to nator verified the CMS form a provided to R128 or his legal 10/18/12, at 3:00 p.m., MDS d that R128 would have or Medicare Part A services, emain in the facility, based on ed nursing needs. ited Review, Notice of erage Procedure revised 4/12 would notify Medicare decision to terminate Medicare in two days before coverage of nated. AND RESPECT OF		156	 Resident's was interview his careplan was updated his privacy curtain prefe Interviewable residents interviewed regarding an potential concerns they have regarding privacy. Staff education was common F241. Caring partner checklist be audited weekly. Audit results will be revely by facility QA committed. NHA is responsible for compliance. 	d with rence. will be ny may npleted s will	11/27/12 11/27/12 11/27/12

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S COMPLI	
	245186	B. WIN	۱G		Į.	C
			75	05 COUNTRY CLUB DRIVE	10/1	3/2012 1964 2017
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
indicated R130 requence encouragement, su for personal hygien required one personal room.	uired minimal assistance of pervision and cues from staff e and dressing needs. R130 n physical assist for walking in	F2	241			
regarding nursing s during morning care preferred to wash h bedside, to sustain would leave his roo who passed by to v expressed his frust want others to see his multiple request	taff not providing him privacy es. R130 indicated that he imself in the mornings, at his his independence and staff m door wide open for people iew him naked. R130 rations and said no one would them naked and that despite is to have his room door shut,					012 E0 E0 E012 E014 E014 E014 E014 E014 E014 E014 E014
Registered Nurse, I assistants (NAR) di room doors and ned would conduct audi that NARs may nee importance of ensu 483.15(g)(1) PROV RELATED SOCIAL	RN (B) verified that nursing d not always shut residents' eded reminders when RN (B) ts of cares. RN(B) indicated d further education on ring privacy during cares. ISION OF MEDICALLY SERVICE	F 2	250	1. The family's goals and expectation care, services, and prognosis were documented in resident's record.		11/27/12
services to attain or practicable physical well-being of each r This REQUIREMEN by:	maintain the highest I, mental, and psychosocial esident. IT is not met as evidenced			makers will have goals of care documented in their record. 3.) Staff education will be complet F250 requirements. SS staff educa on F250 and EHSI SS assessment p4.) Weekly audits of SS assessment ensure family goals of care are addressed. 6.) Administrator is responsible for	ed on tion policy. at to	(12 (10 (10 (10 (10 (10 (10 (10 (10 (10 (10
	PROVIDER OR SUPPLIER VALLEY REHABILIT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa indicated R130 requencouragement, su for personal hygien required one personal required one personal required one personal required to wash headside, to sustain would leave his roo who passed by to vexpressed his frust want others to see his multiple request the staff did not do On 10/17/12, at 2:1 Registered Nurse, If assistants (NAR) diroom doors and new would conduct audit that NARs may nee importance of ensu 483.15(g)(1) PROV RELATED SOCIAL The facility must proservices to attain or practicable physical well-being of each results.	PROVIDER OR SUPPLIER N VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	PROVIDER OR SUPPLIER NALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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:	PROVIDER OR SUPPLIER NALLEY REHABILITATION AND CARE CENTER VALLEY REHABILITATION AND CARE CENTER VALLEY REHABILITATION AND CARE CENTER VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 flat despite his multiple requests to have his room door shut, the staff did not dit. 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 reminiders when RN (B) would conduct audits of cares. RN(B) indicated that NARs may need further education on importance of ensuring privacy during cares. 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. F 250 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	PROVIDER OR SUPPLIER 245186 245186 245186 245186 3TREET ADDRESS, CITY, STATE, ZIP CODE 7805 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES IN TAG) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) STATE DEFICIENCY (EACH DEFICIENCY MUST DE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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: This REQUIREMENT is not met as evidenced by:

ं- €स

PRINTED: 11/02/2012 **FORM APPROVED** OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPL ILDING	LE CONSTRUCTION	(X3) DATE S COMPLE	
		245186		NG			C 19/2012
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	- 1	750	ET ADDRESS, CITY, STATE, ZIP CODE DE COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427	1	10120 12 11 12 12 12 12 12 12 12 12 12 12 12 12 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 250	review, the facility for communicate with a three residents (R2 services in regards services and progn	failed to effectively a family the goals for one of 262) reviewed for social s to expectations of care and	F:	250			(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	given and did not for honored or respect	ed concerns regarding care eel their requests were ted. The facility did not nicate with the family goals for tions for prognosis.					7 E E
	diagnoses that incluartery occlusion with The admission min completed on 7/27/ not comatose but dunderstood others. language and need Her short and long and she was considered.	d to the facility on 7/20/12, with uded unspecified cerebral th cerebral infarction (stroke). nimum data set (MDS) was /12, and indicated R262 was did not speak and rarely. English was her second ded the services of a translator. term memory was impaired dered severely cognitively					12 FA 12 FA 13 FA 14 FA 14 FA 14 FA 14 FA 15 FA 16 FA 16 FA 17 FA 18
	staff for all activities tube fed. The care area asse 7/31/12, noted she with decision makir was admitted to the hospitalization for b metastasis and bra communicate relate	oreast cancer with brain ain surgery. She was unable to ed to her medical condition acheostomy) and received					

3.4

 $\Delta : \mathbb{Q} \sqcup \mathcal{X}$ 111) à

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP: ILDING	LE CONSTRUCTION	(X3) DATE S COMPLI	
		245186	B. Wil		Resident Ada Primero Control	1	C 19/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	EET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 250	R262's husband an 10/16/12, at 8:34 a. upset about the car verbalized that nurs put in a Foley cathe administered unner resident. They indiffer herself and them member needed to almost continuously adequate care. R2 facility was not doin his mother's needs' staff were making care without family knowledge of her maken and the front of the care without family knowledge of her maken and to insert a catheter. During the interview family stated that a learlier, a nurse cam to insert a catheter. did not know the rai were told the direct them to do so. The during the interview catheter upon her a upon recommendate examined R262, it R262's son stated to mother and did not The family met with after the discussion	d son were interviewed on m. They reported being very e given to R262 and sing staff unnecessarily tried in eter that was not needed and cessary medications to the cated R262 could not speak efore they felt a family be in the resident's room to ensure that she was given 62's son reported he felt the g an adequate job "assessing" and administrative facility decisions about his mother's input and without adequate	F	250			\$ 100 mm m

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		245186	B. WII	NG		1	C 9/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		71	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE FOLDEN VALLEY, MN 55427		(政治)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 250	The family stated the not discussed with to insert the cathete. The family also rep- 10/16/12, that R262 unnecessary Tuber indicated a nurse are for Tuberculosis) exidisagreed with the given to R262. The Mantoux's shortly a facility and they felt unnecessary. R262 nursing staff that the done and should not administered. During an observation of administering insublood sugar was 11 allow her to do so a sugar results were R262 did not need a laboratory (lab) stresident's door and intentions to draw be testing that was ord the husband asked that was to be doned discuss it with the historial error the lab rationale for the lab	hey were upset that this was them prior to getting an order er. orted during the interview on	F:	250			

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WIN	lG		10/	C 19/2012
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP CODE 15 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		. 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	Nursing assistant (10/18/12, at 8:44 a is very involved with reposition resident done in two hours. requested that nursing the times when family does keep corepositioning. She family is pleasant to Registered nurse (10/18/12, at 8:30 a husband had been day. She indicated the resident's breat assessed the resident in any respondent in	NA)-D was interviewed on .m. and verified R262's family he resident care and find staff to if repositioning has not been. She verified the family sing assistants document in a R262 is repositioned and the lose eye on the times of indicated that generally the coall the nursing staff. RN)-C was interviewed on .m. and verified R262's very angry at her earlier in the that he was concerned about thing. She reported she ent and did not find the obratory distress but did not find the obratory distress but did not he also reported that husband once he observed on R262's rought "he was afraid of the tracheostomy with e also reported that penerally R262's are generally cooperative and is reaction earlier today. Viewed on 10/18/12, at 12:30 he was aware of family's corted R262's had been given a ch was not needed as staff had libe the administration of the nunization record. She also ad completed a chart audit of ition on 10/14/12, and had was declining. She then hysician and expressed potential skin breakdown and ician insert a Foley catheter.	F	250			

18.5 18.5

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			PLE CONSTRU B	CTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WI	NG		***************************************	10/	C 19/2012	
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER	:	75	05 COUNTR	RESS, CITY, STATE, ZIP CODE NTRY CLUB DRIVE VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) .	ID PREF TAG		(EACH	OVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHI REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282 SS=D	family's decision to testing at times, wh did not make any in conversations held the family's expectator R262. An interview with the (SW)-A was completed a.m. She reported family concerns, events and up meetings daily, who conditions are discussionally but the discussional but the discussions superficial, (discussional but the discussions superficial, (discussional but the discussions superficial, (discussional but the discussional conditions are discussional family accepting thappen and potention or offered family on a regular condition or offered family to aid them we condition and progreservices had not be for the family's requaddressing the culture 483.20(k)(3)(ii) SEFPERSONS/PER CATThe services provided by the services provid	she was of aware of the refuse medication and lab ich she respected. The DON dication however, there were with the family in regards to ations of care and treatment e social services supervisor ated on 10/19/12, at 11:04 not being aware of R262's en though she attended as every morning and "triage ere reports of residents ussed. She also reported that y meet with R262's husband, were generally very weather etc.) She reported 262's husband on 10/19/12, ad told her that family eave the facility walking. She mily seemed to be having the probably this would not ally R262 was terminal. She can be seen to the with the acceptance of R262 additional services to the with the acceptance of R262 and involved with advocating ests with nursing staff and ural issues presented. RVICES BY QUALIFIED ARE PLAN		250	F282 1.) 2.)	care per plan of care. Residents' oral care will be identified on	needs NAR	0143 4.12 4.13 2143 2143 2143 2143 2143 2143 2143 21	
	accordance with ea	ch resident's written plan of				care sheets and plan	of care.		

Ø 42

11.25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WIN			1	C 542 9/2012	
	ROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 105 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	10/1	31 2012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	by: Based on observate review, the facility for provided in accordate of care, related to other (R29) reviewed in the living. Findings include: R29 diagnoses that dementia. The annual minimum 9/20/12, revealed R assistance for all actincluding eating and including eating and including eating and including diagnoses that dementia. The plan of care dainstructed staff to provide the plan of care daily at the nursing assistant dentified R29 required During observation nursing assistant (N morning cares to R2 transferring R29 to observed to utilize a briefly wipe R29's upper R2	ion, interview and document ailed to ensure services were ance with each resident's plan aral hygiene for 1 of 3 residents are sample for activities of daily included brain injury and attained as et (MDS) dated at 29 required extensive activities of daily living (ADLs), at personal hygiene. Ited 10/8/12, revealed R29 rovide physical assistance and as needed. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. Int care sheet, undated, ared assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs. In 10/18/12, at 8:13 a.m., IA)-L and NA-M provided assist of one with ADLs.	F 2	282	3.) Staff education will be completed on proper techniques when provoral care. 4.) Weekly audits of oral will be completed. 5.) Oral care audit results reviewed by facility Q committee. 6.) Director of Nursing is responsible for compli	care will be	11/27/12 2012 2012 2012 2012 2013 2012 2012 20	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	
		245186	B. WIN	1G _			C 19/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	REET ADDRESS, CITY, STATE, ZIP (7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	CODE	V190
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION : DATE
F 282	During interview on manager (CM)-B re to use a tooth brush or at a minimum an for a resident who was buring interview on NA-M verified that s for R29's oral cares NA-M reported that	10/18/12, at 12:28 p.m., case ported that NAs were trained in for completion of oral cares, oral swab with mouth wash was edentulous. 10/18/12, at 12:32 p.m., she did not use an oral swab the morning of 10/18/12. she typically utilized a damp	F2	282			4012 400 501
F 312 SS=D	added, "There were were none in her dr were none in her dr The facility's proced MOUTH CARE, und to be provided to a The procedure outlibe allowed to rinse a soft toothbrush or be used to clean the the insides of the cl 483.25(a)(3) ADL CDEPENDENT RES A resident who is undaily living receives maintain good nutriand oral hygiene. This REQUIREMENT by: Based on observative review, the facility favore unable to carr	dure for ASSISTING WITH dated, identified that oral cares resident who was edentulous, ned that the resident was to with water or mouthwash and sponge-tipped swab was to e resident's gums, tongue and neeks.	F3	312	F312 1. R29 will receive according to pla will receive bath according to his R14 was intervipreference and twas updated. 2. ADL preference identified on Na each resident. 3. Staff education on oral care and 4. ADL audits will weekly. 5. Audit results will by facility QA of the property of the prop	an of care. R141 hing assistance plan of care. ewed for the plan of care es will be AR sheet for was completed bathing. I be completed	10/19/12

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		245186	B. WING		1	C 19/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER	75	EET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		***
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 312	personal hygiene a additional bathing f and R14) reviewed daily living. Findings include: R29 was depender personal hygiene a	nd address requests for or 3 of 3 residents (R29, R141 in the sample for activities of at upon staff assistance for nd received inadequate oral	F 312			384
		by observation on 10/18/12. t included brain injury and				
	9/20/12, revealed F cognitive skills for demonstrated signs The MDS also indicate.	m data set (MDS) dated R29 had moderately impaired daily decision making and s and symptoms of delirium. cated R29 required extensive DLs, including eating and				34
		nted 10/8/12, revealed R29 rovide physical assistance and as needed.	-			100 miles
		ant care sheet, undated, ired assist of one with ADLs.				
	10/18/12, from 8:10 a.m., nursing assist provided morning of room. After transfe NA-M was observe washcloth to briefly gums. R29 was no	ations were made of R29 on a.m. to 9:30 a.m. At 8:13 ant (NA)-L and NA-M ares to R29 in her resident rring R29 to her wheelchair, d to utilize a dampened wipe R29's upper and lower ted to be edentulous (without No further oral care was				

1.11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		iultipi Lding	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WI			40%	C	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP CO 05 COUNTRY CLUB DRIVE 0LDEN VALLEY, MN 55427		19/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	provided. R29 was room, where NA-M assistance to eat. R29 out of the dinir wheelchair in the haroom, near the nurs remained in the hal cares provided. During an interview case manager (CM trained to use a too cares, or at a minin wash for a resident added, "I don't think use a washcloth." During interview on NA-M reported that wash cloth for oral typically utilized a d R29's oral cares. Nuse an oral swab for 10/18/12. NA-M in her room, there was a continuous to be provided to a The procedure outlibe allowed to rinse a soft toothbrush or be used to clean the the insides of the cl The facility did not procedure outlibe allowed to rinse a soft toothbrush or be used to clean the the insides of the cl The facility did not procedure outlibe allowed to clean the the insides of the cl The facility did not procedure outlibe allowed to clean the the insides of the cl The facility did not procedure outlibe allowed to clean the the insides of the cl The facility did not procedure outlibe allowed to clean the the insides of the cl The facility did not procedure outlibe allowed to clean the the insides of the cl The facility did not procedure outlibe allowed to clean the the insides of the cl	then brought to the dining was noted to provide R29 with At 8:45 a.m., NA-M brought of room and placed her allway outside her resident se's station. At 9:30 a.m., R29 lway, with no additional oral on 10/18/12, at 12:28 p.m.,)-B reported that NAs were the brush for completion of oral num an oral swab with mouth who was edentulous. CM-B it would meet the standard to 10/18/12, at 12:32 p.m., she did not typically use a wet cares. She reported that she amp "toothette" or swab for IA-M verified that she did not or R29's oral cares the morning added, "There were no swabs were none in her drawer." Iture for ASSISTING WITH dated, identified that oral cares resident who was edentulous. Indeed that the resident was to with water or mouthwash and sponge-tipped swab was to be resident's gums, tongue and neeks. Orovide frequent bathing who was totally dependent	F	312			2012 VED 1391 1391 1391 1391 1391 1391 1391 139	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	iultipi Ilding	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WII	NG		1	0 9/2012	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	***************************************	750	EET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		: 41 - 41 - 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 312	R141 had diagnose The quarterly minir identified R141 was did not reject any a daily living, and red staff member with During interview or family-B stated R14 his hair being comb had been somethir hair and when she bunch of it fell out. about the hair, but the hair hadn't yet lindicated this was a gone a long time wexplained when R1 facility he went neawashing. Family-B enjoys having his h The care plan date to be neat, clean as care plan identified showering and con The nursing assists was to be bathed of The bathing care to 10/18/12 (20 weeks 12 showers and 2 to 12 showers and 2 to 13 days) R141 onloccurred on 7/14/1 tracker report reveals	es that included dementia. mum data set dated 9/14/12, so severely cognitively impaired, assistance with activities of puired physical assist of one bathing. 10/16/12, at 12:27 p.m. 11 had gone for a week without bed. Family-B explained there ag sticky such as syrup in the tried to comb R141's hair, a Family-B talked with staff upon returning a week later, been washed. Family-B not the first time R141 had ithout proper care and 41 first was admitted to the rily a month without hair state, "It's too bad as he really lair washed." d 6/1/12, revealed R141 was and well groomed daily. The R141 required assistance with abing hair.	F	312				

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	ETED
		245186	B. WI	NG_			C 9/2012
	ROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		- 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	to R141 on 9/28/12 During interview on registered nurse (R frequently did well is cooperative. RN-D explanation as to wo weekly. During interview on nursing assistant (R showers to R141 or and confirmed R14 shower. NA-G remon 10/11/12, becaut NA-G was unable to missed so many should be missed so many should be made to that included morbion of the admission Min worksheet dated 5/ somewhat important a bath, shower or sidentified R14 preferor sponge bath. The 8/22/12, identified to and required extensibathing.	n 10/18/12, at 9:43 a.m., RN)-D indicated R141 in the shower and was was unable to provide an why R141 was not bathed in 10/18/12, at 10:15 a.m., NA)-G recalled providing occasionally since admission in was cooperative in the embered the last shower given use of the syrup in R141's hair. To explain why R141 had nowers. In provide assistance with ing to R14 who requested in the facility with a diagnosis of obesity. Imum Data Set (MDS) 26/12, identified it was not for R14 to choose between aponge bath. The form perred a shower over a tub, bed the quarterly MDS dated that R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive assist of two staff for the standard R14 was cognitively intact sive as standard R14 was cognitively intact sive as standard R14 was cognitively intact sive as standard R14 was cognitively intact sit was the standard R14 was cognitively intact sive as standard R1	F	312			7 42 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
							~

1145

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WII	√IG		10/	C 19/2012
	PROVIDER OR SUPPLIER	ITATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP COL 5 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	On 10/16/2012, at only get one show every day but eve would be okay." Fyeast infection be showers because every day. At hom day." R14 stated who helped her ta wanted a bath mo interview a strong of the room. On 10/17/12, at 1: still like more shown because of my humiliates me. An washing up in bed more often." On 10/18/12, at 9: -K stated R14 reconstruction Saturdays. NA-K resort than one shown on the shown of the shown of the shown of the shower reported she also 10/17/12, that she frequently. R14 stated 10/17/12, but the shown of the show of the shower reported she also 10/17/12, but the she frequently. R14 stated 10/17/12, but the she show of the show of the show of the shower reported she also 10/17/12, but the she frequently. R14 stated 10/17/12, but the she show of the show of the shower reported she also 10/17/12, but the she she show of the she shower reported she also 10/17/12, but the she she she she she she she she she s	t 8:23 a.m., R14 reported, "You ver a week. I would like one in two or three times a week R14 went on to state, "I get a cause I don't get more frequent I sweat. They wash you up it I always showered every she told the nursing assistant ke a bath last Saturday that she re frequently. During the odor was noted on R14's side 47 p.m. R14 stated, "I would wers. Right now I get yeast build folds. It's so strong it just d I don't care what they say I doesn't help, I need to shower 03 a.m. nursing assistant (NA) eived one bath a week on reported if a resident requested ower a week the staff would 2:02 a.m. trained medication A)-A stated he worked on reported R14 liked to take a	F	312			112 12 14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WII	۱G		10/19) 2/201	2
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			7.0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		X6) PLETION ATE
F 312	were busy". R14 furmany times she wa a week because sh stated no one has ewhether or not they shower a week. R1 informed the case r told enough people. On 10/18/12, at 12: requested a shower NA-B stated she wastaff did not have the night of 10/17/12. Nalmost every night reported if R14 war second shower she nurse (RN)-A. NA-E request to RN-A be process here. On 10/18/12, at 2:1	rther stated she told staff nted a second or third shower e felt like she smelled. R14 ever gotten back to her on could provide more than one 4 verified she had not manager, but stated "haven't I, why aren't they telling him?" 43 p.m. NA-B confirmed R14 r the evening on 10/17/12. as scheduled for Saturday and me to give her a shower the IA-B stated R14 calls out requesting a shower. NA-B sted to be scheduled for a should talk to the registered B stated he did not bring R14's cause that was not the	F	312				7012 1VED 0391
	had not informed hishowers more frequent should be let him knower frequent show them into the sched have some issues wand understood her showered more fred On 10/18/12, at 2:30 helped R14 with he verified R14 told he shower every other NA-D stated she tol she only worked the	m of R14's request to take uently. RN-A stated staff now if a resident requests wers so the facility could work lule. RN-A verified R14 did with yeast due to her skin folds concern with wanting to be			-			12 12 12 12 12 12 12 12 12 12 12 12 12 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIF LDING	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245186	B. WIN	1G		10	C /19/2012
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE 505 COUNTRY CLUB DRIV OLDEN VALLEY, MN 5	, ZIP CODE E	389
(X4) ID PREFIX TAG				ıx	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 312 F 322 SS=D	was to tell the resident manager know and themselves. 483.25(g)(2) NG TRESTORE EATING Based on the compresident, the facility who is fed by a narreceives the approto prevent aspiration to prevent aspiration to prevent aspiration of the property of the province of the p	dent to let the RN-A case do not inform the case manager REATMENT/SERVICES - G SKILLS prehensive assessment of a y must ensure that a resident so-gastric or gastrostomy tube priate treatment and services on pneumonia, diarrhea, ion, metabolic abnormalities, eal ulcers and to restore, if		312	adverse signs result of obse 2. Other resider identified and will be updat for g-tube. 3. Staff education completed or procedures. 4. Weekly audit procedures weekly such as the complete of t	on will be a g-tube will be a g-tube will be completed. The completed at facility be.	10/18/12
	medications and n administered acco Findings include: On 10/18/12, at 8:2 -C was observed to nutritional supplem check placement of addition, RN-C use fluids, which include	cility failed to ensure that utritional feedings were rding to the facility policy. 20 a.m. registered nurse (RN) administer fluids and lents to R262, and did not of the gastrostomy tube. In ad a large syringe to administer ed water and Jevity 1.5 lent and pushed the liquids into be.					12 12 12 12 12 12 12 12 12 12 12 12 12 1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245186	B. WIN			1	C 9/2012	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		78	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 322	R262's physician or centimeters (cc) of can) be administered tube (g-tube) four till water before, during RN-C was interview and verified she had placement of the g-some nurses at the administer medication nurses use the syrical force.	ge 20- rders specified that 250 cubic free water and Jevity 1.5 (1 red through the gastrostomy mes per day with 50 cc of g and after the feeding. red on 10/18/12, at 8:30 a.m. d forgotten to check the tube. She also reported that facility use gravity to on via the g-tube and other nge method. RN-C reported what the facility's policy	F	322				
F 329 SS=D	10/18/12, at 2:13 p. expected all nursing fluid/medication via method for adminis placement of the gliquid or medication copy of pages from as the facility's procenteral (tube) feedin directed staff to che gastrostomy tube pliquid and if the staf syringe would be fill through the tube int 483.25(I) DRUG REUNNECESSARY DEACH resident's druunnecessary drugs drug when used in duplicate therapy);	res (DON) was interviewed on m. She reported she g staff who administered any the g-tube to use the gravity tration and to check tube prior to introducing any. She provided a photocopy the Lippincott Nursing Manual edure for administration of ags. The provided document eck placement of the rior to administration of any f used a large syringe, the ed and allow fluid to flow the stomach by gravity. EGIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate	F3	329	F329 1. R31 had pharmacy chart and IDT review of medicati R31 also had a comprehens assessment. 2. Facility audit of other recon antidepressant and antian	ions. ive sidents	11/27/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245186			C 10/19/2012			
	ROVIDER OR SUPPLIER	TATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
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.		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 2012 2012 3010 3911		
	by: Based on interview facility failed to add monitor clinical indeffectiveness and for 1 of 10 residen regimen was review Findings include: Resident (R31) was treat anxiety and pure (mg) three times danxiety since 03/02 (antidepressant) 2	NT is not met as evidenced w and document review, the equately identify, assess and ications to evaluate the continued use of medications ts (R31) whose medication wed. s receiving xanax (used to anic disorders) 0.5 milligrams aily as needed (PRN) for 2/12, and trazodone 5 mg daily at bedtime as ince 01/26/10. Both				10 12 (10 m) (10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WII	√G	<u> </u>		C 9/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	R31 was admitted to with diagnoses that insomnia, schizoph. An annual Minimum assessment, dated cognitively intact with multiple mood indictively interest and bad about. The current physicial indicated R31 had to three times daily as trazodone 25 mg at addition, R31 received 0.5 mg for anxiety expression of R31 received 1.05 mg for anxiety expression o	and trazodone) were ut adequate monitoring. o the facility on 02/14/2001, included panic disorder, renia and depression. In Data Set (MDS) 07/03/12, identified R31 as the no behavioral issues and actors (examples included: interest in activities, feeling self) were coded on the MDS. an's order, dated 10/09/12, been receiving xanax 0.5 mg needed (PRN) for anxiety and bedtime PRN for sleep. In wed scheduled doses of xanax every morning and trazodone for anxiety. provided the psychiatrist's worker visits to R31 (twice in pril, four times in May, once in gust 2012), the ed a comprehensive specific anxious behaviors, atterns and review of facility on on R31's specific ides to justify the use of PRN	F	329			

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLI LDING	E CONSTRUCTION	(X3) DATE SI COMPLE		
		245186				I	C <mark>9/201</mark>	2
	OVIDER OR SUPPLIER	ITATION AND CARE CENTER	:	750	ET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	COMP	X5) LETION ATE
t Caiii e ii ii r v c c r pf	Doctober 2012. The appropriate monitor all appropriate interventions after interventions. In a monitor all appropriate with use of these porthostatic blood pliary," record individually attern, otherwise acility staff monitor atterns to justify and diagnosis of a paranoid schizophieen receiving the ears. RN-B indicated are tracker (compared for PRN medication are tracker (compared for progress notes and diagnosis of a progress notes and diagnosis of a progress notes are tracker (compared for PRN medication are tracker (compared for progress notes and diagnosis of a progress notes and diagnosis of a progress notes are tracker (compared for PRN medication are tracker (compared for PRN medication are tracker (compared for PRN medication, in the progress notes are all the	er 2012 and one time in the medical record lacked oring of these medications, anxious/panic behaviors any non-pharmacological opted and outcome of these addition, the facility did not wriate side-effects associated medications, for example oressures. A "7 day sleep cated staff monitored only three of the the was no evidence the ored R31's sleep/awake the use of Trazodone for sleep. Oo p.m. and 1:45 p.m., Unit red Nurse, RN(B) stated R31 inxiety, panic attacks and interest and the resident did not exhibit res, rather would alert the low she felt and would request ons. RN-B added, the nursing in the progress notes and in puterized documentation) when a medications. After reviewing and the care tracker data, appropriate monitoring cluding side-effect monitoring.	F	329				THE REPORT OF THE PARTY OF THE

15MC

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION IG	COMPLI	ETED
		245186	B. WI	1G _	-	1	C 9/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	REET ADDRESS, CITY, STATE, ZIP CODE 1505 COUNTRY CLUB DRIVE BOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371 SS=E	The facility must - (1) Procure food fro considered satisfact authorities; and (2) Store, prepare, under sanitary cond This REQUIREMENT by: Based on observative the facility fatemperatures that into minimize the risk had the potential to who received supply Findings include: A review of the Equative last five months have a system in playing include as the nutrition of the primarily the nutrition o	om sources approved or story by Federal, State or local distribute and serve food ditions NT is not met as evidenced stion, interview and document alled to monitor refrigerator held potentially hazardous food to of food borne illness. This affect 74 of 153 residents demental snacks. Interview and document alled to monitor refrigerator food here illness. This affect refrigerator affect refrigerators affect refrigerators and supplement refrigerators, and supplement refrigerator, defor proper holding the control of the control	F	371	F371 1. Temperature of nourishmological refrigerator was immedicated to validate it was appropriate temperature. 2. Temperature logs are in for all refrigerators in the kitchen. 3. Staff were educated on I requirements. 4. Temperature logs will be audited for compliance applicy. 5. Audit results will be subto the facility QA common review. 6. Dietary Manager is responder compliance.	iately as at place place re r371 e with comitted pittee for	10/15/12 10/15/12 11/27/13 11/27/13
		us foods such as an meat, cheese, yogurt, chicken			-		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTI	RUCTION	(X3) DATE SURVEY COMPLETED C		
		245186	B. WIN	۱G		10			
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		78	505 COUNT	SS, CITY, STATE, ZIP CODE TRY CLUB DRIVE ALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EA	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 425 SS=E	(DM) confirmed the temperature log ind monitored for the laws not a thermomensure potentially hwithin the proper rabacterial growth and The facility's Refrige Log Policy, indicate Services, Inc., (EHS Refrigeration Temptemperature record freezers units taken PM shifts in order to problems quickly." 483.60(a),(b) PHAF ACCURATE PROCOURATE PR	eggs, and milk. 4 p.m. the dietary manager nourishment refrigerator icated it had not been st month. DM verified there eter in the refrigerator to azardous foods were held nge to minimize the risk of d food borne illness. erator/Freezer Temperature d, "Extendicare Health SI) promotes the use of erature Log (Copy Form) as a for all refrigerator and twice daily on the AM and a store foods safely and detect standard to its residents, or obtain the ement described in eart. The facility may permit el to administer drugs if State y under the general ensed nurse. de pharmaceutical services es that assure the accurate dispensing, and drugs and biologicals) to meet		371	2.)	Resident #292, has since discharged from the facil other cited residents are residents medications were reviewed during the survey. NHA and DON apharmacy 10/21/12 to revitimeliness of medication delivery. Licensed staff were re-ed on the timely ordering of medications.	eceiving er. sheets MDH met with view	2012 2012 2012 2012 2012 2012 420 420 421	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245186	B. WI	1G		1	C 9/2012
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	•	78	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		(2) (2) (2) (2) (3) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	on all aspects of the services in the facili	e provision of pharmacy ity.	F	125	 4.) DON or designee to audit 5 MAR's for missed doses on weekly basis to identify any residents not identified in the medication error process. 5.) Audit results will be reviewe the facility QA committee. 6.) DON is responsible for 	e	11/27/12
	by: Based on observat review, the facility fa services were secu- medications and bio residents (R292, R270), reviewed for	ion, interview and document alled to ensure pharmaceutical red, including routine blogicals as ordered for 6 of 9 161, R284, R51, R30 and missed medication doses not being available for			compliance.		V 12 779 971 971 2012 7650 7651
	Findings include:						
		administered timely for R292 on being unavailable.					77A
		to the facility on 9/28/12, with closed fractures of the umerus.					
	was to receive oxyc (Percocet) 5-325 m	nted 9/28/12, revealed R292 codone/ acetaminophen g, one to two tablets by mouth needed for moderate to					17.
	to approach license stated, "Have you g LPN-R replied, "No,	25 p.m., R292 was observed d practical nurse (LPN)-R and ot my Percocet yet?" When "R292 was noted to sigh					7, 10
		er head. R292 then stated that ne that the facility had run out					

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		1` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				C - 10/19/2012				
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	- 	750	ET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		1.1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 425	of her medication. facility's process for pharmacy and whe medications in time ordered. LPN-R verifications "at time resident medications residents had to mi ordered by their phythe facility's process to remove the label was getting close to then to be placed or to the pharmacy. Limedication was need were to call the pharmacy. Limedication order from the medication order from the medication label to when she arrived for days later," the medication is the medication order the medication factor of the medication was need to the pharmacy and recent the resident has result of the medications, she would pharmacy and recent that the re-fill date of the indicated to the pharmacy and recent that the re-fill date of the indicated that she has medication refills to	LPN-R was asked about the rordering medication from the ther they had difficulty getting to administer them as diffied the facility had run out of es" and had not received as timely, to the point that as doses of medications ysician. LPN-R reported that as for refilling medication was from the medication "when it or running out." The label was not a sheet of paper and faxed PN-R reported that if a eded right away, the nurses armacy and request a stat atton. LPN-R reported that she able to receive a stat of the pharmacy within two att. LPN-R reported that there is when she had faxed a the pharmacy for refill and or her next shift "a couple of dication had still not arrived a missed several doses as a aution not being available. It when she encountered these led call in a stat order to the ived the medication within two red that she was not sure occurring, other than to guess on the label may have armacy that the medication did until that date. LPN-R ad reported this problem with the unit care manager (CM) that she was awaiting a stat	F	125				

1156

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. Wil				C 19/2012	2
	ROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP COD 5 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPL DA	5) ETION TE
F 425	During an interview R292 reported that at 7:00 a.m. and his 11:00 a.m., when so of the medication. eight on a scale of awful throbbing described her pain area, down her arreported pain in he R292 stated, "It is for her pain medicated to 10 (on a scale of as needed Percompost administration." Review of medicated (MAR) for 10/1/12 tablets of Percoced administered to R2 Review of progress LPN-R on 10/17/12 tablets of Percoced administered to R2 Review of progress LPN-R on 10/17/12 tablets of progress trun, hopefully swhen writer told he but could take up to Resident [at] 12 Nowiter asking if pills was still very upset given, but resident	v on 10/17/12, at 12:40 p.m., the last received her Percocet and requested another dose at she was told the facility was out R292 identified her pain as an one to 10. R292 stated, "It's aching horrible." R292 as from her left shoulder/ neck and into her hand. She also or right knee to quadriceps. unacceptable," having to wait action. Pain Flow Sheet from 10/1/12 ed consistent pain ratings of 8 f 10) prior to administration of et and pain ratings of 1 to 4 nof as needed Percocet. Ion administration record to 10/17/12, revealed two 5-325 mg were last 192 at 7:30 a.m. on 10/17/12. Is note for R292, signed by 2, at 3:00 p.m. read, "At about resident asked for more pain 8/10, at the time pills were to get them to come out on that. Resident was very upset of that 'the pills were on the way of 4 [four] hours to get here.' con [12:00 p.m.] re-approached thave arrived yet resident to be denied. At 1400 [2:00 p.m.]	F.	125				
		denied. At 1400 [2:00 p.m.] given 2, relief noted at 1500						V .

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' ′	IULTIP	ELE CONSTRUCTION	COMPLE	ETED
		245186	B. WII	√G		I .	C 9/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 06 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		3(12 4) 331
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	[3:00 p.m.]." Six medication dose to the medication madministration. R161 diagnoses ind (decreased secretic produced by the pit. Physician orders dawas to receive an irdaily for hypopituita indicated for replace. Review of the MAR revealed R161 was of genotropin as so 9/1/12, 9/2/12, 9/3/2 Review of Medication 10/17/12, revealed was not administered through 9/6/12, due coverage. No ill eff these errors. Medication was not due to the medication R284 diagnoses incoming 19/20/12, revealed R161 R284 R161 R284 diagnoses incoming 19/20/12, revealed R161 R161 R161 R161 R161 R161 R161 R16	es were missed for R161 due of being available for cluded hypopituitarism on of hormones normally uitary gland). ated 9/29/12, revealed R161 njection of genotropin, 0.4 mg rism. Genotropin was ement of growth hormone. for 9/1/12 to 9/30/12, not administered the injection heduled, at 8:00 a.m. on 12, 9/4/12, 9/5/12 and 9/6/12. on Error Report dated the medication genotropin ed to R161 from 9/1/12 to a delay in insurance fects were noted as a result of administered timely for R284 on being unavailable.	F	425			

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIP LDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		245186	B. WII	NG		1	C 19/2012
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		: : :
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 425	Physician orders do was to receive calco (milligrams), four control daily with meals and renal disease. Phosof hyperphosphate factor for cardiovast patients). On 10/17/12, at 12 the facility nurses word medication that he lunch. R284 reported that help break down himedication before R284 reported that served in the facility wait to eat because medication. During interview on LPN-R verified that R284's PhosLo at 100ked in her medication bubble pre-packaged med reported that once PhosLo pills left for pharmacy to request medication. LPN-R had since called bat the medication cart was available in the bottles. LPN-R rep	ated 9/27/12, identified R284 ium acetate (PhosLo), 667 mg apsules by mouth three times d at bedtime for end stage is Lo was indicated for control mia (a well-recognized risk scular mortality in dialysis and perfect that were refusing to administer a needed in order to eat his red, "They're telling me they ication that they're out of it." he needed the medication to so food and he had to take the ne ate or he would get sick. They he had not received this at 11:30 a.m. and he had to he had not received this as 10/17/12, at 12:15 p.m. she was going to administer and to a cart, she noticed that is Lo pills left in R284's	F .	125			A STORY

: Fisher

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG 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,	2012		
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 (millillers) 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,			
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,	(X5) OMPLETION DATE		
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,	70 AZ		
on 10/9/12, with a note indicating the medication was not in stock.	cen de de de de		
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			

Exployer.

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	-	245186	B. Wi	۱G _		1	C 9/2012	
	ROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		7!	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE SOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	ON
F 425	available.	ge 32 to the medication not being uded paranoid schizophrenia.	F,	425				
	was to receive an ir decanoate (Prolixin weeks (Monday ove Prolixin Decanoate	ated 10/3/12, revealed R30 njection of fluphenazine Decanoate) 50 mg every two ernight shift) for schizophrenia. was indicated as a long-acting dividuals with chronic						012 ED 01
	revealed R30 was r	for 10/1/12 to 10/17/12, not administered the injection te as scheduled during the 2.					-	
	revealed the medica not offered to R30 t reason for error was administration." No	on Error Report dated 10/9/12, ation Prolixin Decanoate was he morning of 10/9/12. The s noted as, "Not available for adverse reactions were noted 0's physician was promptly cation error.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
	through 10/11/12, re Decanoate was not was reordered on 1 indicated that once by the pharmacy, R	notes for R30 from 10/9/12 evealed the Prolixin administered on 10/9/12, but 0/9/12. Subsequent notes the medication was delivered 30 refused the injection essful administration on					(20) (3)	12 12 12 12 12 12 12 12 12 12 12 12 12 1
	Medication doses we the medication not la administration.	vere missed for R270 due to being available for					J	772 74 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. Wil	NG			C 9/2012	
	ROVIDER OR SUPPLIER	TATION AND CARE CENTER		78	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		1842 8425	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) (X5) (X5) (X5) (X5) (X5) (X5) (X5)	
F 425	Continued From pa	ge 33	F	425				
	R270 diagnoses in	cluded depression.					744	
		ated 9/1/12 revealed R270 was m (Celexa) 20 mg daily for feeding tube.						
	revealed R270 was mg dose of Celexa	for 10/1/12 through 10/17/12, not administered her daily 20 on 10/14/12 and 10/17/12. cated that only a half dose was /16/12.					1.12 7. 10 13.74	
	10/17/12, revealed not administered as 10/14/12 and 10/17 that only a half dose 10/16/12. The repotaken to prevent sir nurses to report mis	on Error Report dated the medication Celexa was s scheduled at 8:00 a.m. on 7/12. The report also indicated e was administered on ort noted that precautions milar errors included educating ssing doses. R270's physician e missed doses on 10/17/12,					10.00 10.00	
	CM-E verified the far prescriptions from that she had taught least 24 hours ahead needed, by removing medication and faxion and faxion for administrative for administrative for a medication and to wait for a medication and to wait for a medication. She	10/17/12, at 12:50 p.m., acility's process for refilling he pharmacy. She reported the nurses to request refills at ad of the time they were ag the label from the ring the label to the pharmacy, ad also trained the nurses to or a stat order if the ordered ion was drawing near. CM-E owledge, the longest the facility edication from the pharmacy denied being informed of any missed doses of medications						

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE S COMPL	ETED	
		245186	B. WIN	G	Bridge of the Control		C 19/2012	
	ROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 425	due to medication. During follow-up ir p.m., LPN-R agair concerns of reside medications order being available. Lethis concern to CN During interview of director of nursing having "significant pharmacy. DON resident allowing for a relying on facility serving on facility serving on facility serving on facility serving the medications insurance coverage by the facility) to each the pharmacy had contract. DON state authorized place to prescription," desparement to cover those circumstant facility was also had pharmacy "dropping be on-going. DON errors due to medication errors survey entrance, it doses that nursing until the time of the	nterview on 10/17/12, at 1:25 verified that she had reported ents who had missed doses of ed, due to the medications not PN-R verified she had reported	F4	25			9: KS	

j 76

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		245186	B. WIN	G	C 10/19/2012		
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 428 SS=D	being unavailable for reported it was her medication was not the nurse would cirk MAR, write on the medication was not supervisor so follow physician could be The facility's Medicarevised 7/10, instrumedication assistar any dose omission back of the MAR. acceptable to omit medication not available to omit amedication not available, contarmacist and requipment available, contared available, contared available, contared at least or pharmacist. The drug regimen or reviewed at least or pharmacist. The pharmacist muthe attending physical nursing, and these	or administration. DON expectation that if a available for administration, cle the dose missed on the back of the MAR that the available and notify their y-up could occur and the notified. ation Administration Procedure cted licensed nurses and/ or nt's to indicate the reason for in progress notes or on the The policy noted, "It is not a dose by indicating 'NA' for lable from pharmacy. m Back-up Supply/ ontact pharmacy or on-call uest medication to be sent bossible]. If the medication is of the physician for further	F 4:	F428 1.) Resident #31 had her pharmacist reports rev Sleep assessment was completed. 2.) Facility will review al with antianxiety and hemedications.	riewed. I residents hypnotic dements in hyproaches letted opriate nation. Orought to ge for		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		245186	B, WII	۱G			C 19/2012
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	•	750	ET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN					(X5) COMPLETION DATE
F 428	by: Based on interview Consultant Pharma 10 residents (R31) reviewed included a efficacy was in place Findings include: Resident (R31) was treat anxiety and pa (mg) three times da anxiety since 03/02 (antidepressant) 25 needed for sleep si medications (xanax administered without R31 was admitted t with diagnosis that insomnia, schizoph An annual Minimum assessment, dated cognitively intact wi multiple mood indic interest in activities self) were coded or Current physician's indicated R31 had the three times daily as trazodone 25 mg at addition, R31 receiv 0.5 mg for anxiety e 25 mg twice a day for	and document review, the distribution of the facility on 02/14/2001 included panic disorder, renia and depression. The Data Set (MDS) 07/03/12, identified R31 as the no behavioral issues and rators (feeling down, little, feeling tired and bad about the MDS. order, dated 10/09/12, oeen receiving xanax 0.5 mg aneded (PRN) for sleep. In yed scheduled doses of xanax every morning and trazodone	F	428			

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

			(X3) DATE S COMPLE					
		245186	B. WI	NG		1	C 9/20 1	12
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427			1.12 <u>1.12 1.12 1.12 1.12 1.12 1.12 1.12</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COM	(X5) PLETION PATE
F 428	and licensed social February, once in A July and once in Au documentation lack evaluation of R31's sleep and awake pastaff's documentation panic/anxious episoxanax and trazodor Medication Adminis July 2012 to presen R31 used PRN xan in August, 21 times October 2012. Train September 2012 The medical record of these medication anxious/panic behanon-pharmacologic outcome of these in facility did not monit associated with use example orthostatic sleep diary," record nights in May (5/11, sleep pattern, other the facility staff mor patterns to justify the On 10/18/12, at 1:0 Manager, Registere had diagnosis of an paranoid schizophre been receiving thes years. RN-B indica exhibit explosive be	worker visits to R31 (twice in April, four times in May, once in Igust 2012), the sed a comprehensive specific anxious behaviors, atterns and review of facility on on R31's specific odes to justify the use of PRN	F	128				

 $\{ \cdot, \cdot \}_{i=1}^n$

. 47

			(X3) DATE SURVEY COMPLETED			
		245186	B. WI	IG		C 10/19/2012
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505 COUN	RESS, CITY, STATE, ZIP CODE ITRY CLUB DRIVE VALLEY, MN 55427	:
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (E/	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 428	for PRN medication staff documented in care tracker (complete administered PRN) the progress notes RN-B verified that a documentation, indivated and the progress of the progr	ns. RN-B added, the nursing on the progress notes and in uterized documentation) when medications. After reviewing and the care tracker data, appropriate monitoring luding side-effect monitoring, 1. 10 p.m. and 4:30 p.m.; the cist, after reviewing R31's rified the nursing staff needed ument on the use of cations. The consulting ed the sleep assessment and cking for R31. The consulting ed that these issues needed to ttention of director of nursing	F	128		10.42 10.42 10.42 10.42 10.42 10.43
F 431 SS=D	directed staff to mo on side effects, nor responses to interv 483.60(b), (d), (e) I LABEL/STORE DR The facility must er a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled.	revised on October 2008, onitor and document regularly narrow approaches, resident tentions, and target symptoms. DRUG RECORDS, EUGS & BIOLOGICALS apploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be	F	1431	 The expired and undat medications were removed. Controlled substances appropriately locked. All medication carts a medication rooms wer for improperly stored medications. Licensed staff were expedication storage. 	oved. are being ind re audited

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. Wil				C 9/2012	
711 1117 - 47 1	ROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	ET ADDRESS, CITY, STATE, ZIP CODE 15 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	SHOULD BE COMPL		
F 431	labeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	sice with currently accepted bles, and include the ory and cautionary expiration date when State and Federal laws, the ll drugs and biologicals in onts under proper temperature to only authorized personnel to	F	431	 4.) Med rooms will be audited weekly and 3 med carts waudited weekly for complete. 5.) Audit results will be submated to facility QA committee. 6.) DON is responsible for compliance. 	vill be iance. nitted	11/27/12 /2012 VED (2391	
	by:	NT is not met as evidenced						
	review the facility farmedications were demodications were not seven medication contrage. The facilit substances locked personnel only and	ion, interview and document alled to ensure open ated when open and expired of administered for one of arts reviewed for medication y also failed to keep controlled and accessible to authorized stored medications with food e refrigerators that were ation storage.					4012 4012 4890 1991	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LDING	E CONSTRUCTION	COMPL	ETED
		245186	B. WI	NG		10/	C 19/2012
	ROVIDER OR SUPPLIER	ATION AND CARE CENTER	¹	750	ET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427		23 12 201 2 2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	On 10/15/12, at 1:4 (a prescription med sugar (glucose) cordiabetes mellitus), refrigerator in the mwas open; however the medication. A review of the Amrecommended stor Byetta Pen was to 30 days, the pen shade there was some medicated when opened dated when opened buring an observation of 10/15/12, at blood thinning medication was found in vial had an expiration the expiration date. During continued remedication cart, two (an inhaler used to obstructive pulmon bottom drawer open opened date labels Advair inhalers wer and each nurse was medications for expito administration.	is p.m., a Byetta injectable pen licine that may improve blood a hirol in adults with type 2 was found in the first floor nedication storage room and r, there was no open date on ylin Pharmaceuticals, Inc. age guidelines indicated the be used for only 30 days. After nould be discarded even if edicine left in the pen. RN)-A verified no open date of that it should have been d. ion of the first floor medication to 2:00 p.m., a vial of Heparin (a ication used to prevent blood the top drawer. The multi-use on date of September 2012. st been administered that 2, at 8:00 a.m., 15 days past	F	431			
				į			3 4 4 4 2 2

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		245186	B. WING	· ·	10/	C 19/2012
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	750	ET ADDRESS, CITY, STATE, ZIP D5 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 5542	CODE	.:
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	Adviar Diskus one foil pouch, or after whichever comes Upon inspection of the third floor dem p.m., a multi dose controlled substant found to be stored Also in the door with the fact open date. License immediately remorplaced it in the local locked medication. Tubresol needed to been opened and used for food storal Ativan should not unlocked refrigeral. Review of the facil Date of Medication Needles policy data not to be stored in general storage arbitologicals are stored in general storage arbitologicals are stored in general storage arbitologicals. Furtherm facility should folloguidelines with resopened medication record the date opensed medication record the date of the da	rage guidelines were to discard month after removal from the the dose indicator reads "0", first. If the unlocked refrigerator on entia unit on 10/15/12, at 5:23 vial of Ativan (a schedule IV ice anti-anxiety medication) was on the top shelf of the door, as a multi dose vial of Tubresold to aid in the diagnosis of a ion) which did not have an ed practical nurse (LPN)-A ved the vial of Ativan and ked refrigerator in the third floor room. LPN-A stated the obe thrown out because it had stored in a refrigerator that was age, LPN-A further stated the have been stored in the	F 431			90N 100N 100N 100N 100N 100N 100N 100N 1

فيهاجف

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
							c	
		245186	B, WIN	G		10/1	9/2012	
	ROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		75	EET ADDRESS, CITY, STATE, ZIP CODE 105 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	expiration date oncindicated the facility controlled substand licensed nursing, pipersonnel designate. Review of the medidated 7/10 revealed medication and expadministration. During interview on consulting pharmaconsulting pha	e opened. Finally, the policy should ensure Schedule II-V ces are only accessible to harmacy and medical	F 4	131			2012 2012 2012 2013 2013 2013 2013 2013	
-							\ \	

PRINTED: 11/02/2012 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION O1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245186	B. WII	NG		10/2	3/2012	
	ROVIDER OR SUPPLIER VALLEY REHABILIT	ATION AND CARE CENTER	-	75	EET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	ΓS	K	000				
	Minnesota Department time of this survey, was found in substate requirements for part Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing This 3-story building was determined to construction. It has automatic fire sprint facility has fire alarm corridors and space monitored for fire defacility has a capacitate the survey of the sur	at 42 CFR, Subpart by from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), Health Care. g was constructed in 1972 and be of Type II (222) partial basement and is kler protected throughout. The m detection in resident rooms, es open to the corridor that is epartment notification. The ity of 175 and had a census of						

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.

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

TITLE

(X6) DATE



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Golden Valley Rehabilitation And Care Center November 2, 2012 Page 2

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

Santo Drebene

Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SU COMPLE	
		00112	•	II. WING		· · · ·	10/19) 9/2012
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY.	STATE, ZIP CODE		77, 70, 63	
GOLDEN	VALLEY REHABILIT	ATION AND CAR	7505 COUN GOLDEN V					
(X4) ID PREFIX TAC	: : (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL :	PREFIX -	EACH CORRECT CROSS-REFERENCE		JLD BE	(X5) COMPLETE DATE
. 2 000	Initial Comments			2 000				
	*****ATTEI	NTION*****	The state of the s					
	NH LICENSING	CORRECTION ORD	ER '					
	In accordance with	Minnesota Statute, se	ection :					
		ction order has been i y. If, upon reinspecti						
	found that the defici	ency or deficiencies	cited					
	nerein are not corre not corrected shall t	cted, a fine for each to a sees a cor	violation 🚶 dance					
		ines promulgated by						
	Determination of wir	ether a violation has	been .					
	corrected requires of	compliance with all rule provided at the t						
	number and MN Ru	le number indicated l	oelow, 👾					
	comply with any of t	is several (tems, failu he items will be cons	idered 🔝					
	lack of compliance, re-inspection with as	Lack of compliance ny item of multi-part r	upon ''					
	result in the assessi	ment of a fine even if	the item 📒					
	corrected.	ring the initial inspect	ion was					
		nearing on any asses						
		non-compliance with a written request is r		: ", : . : .				
	the Department with	in 15 days of receipt it for non-compliance	of a . · ·					
	INITIAL COMMENT On, October 15, 16,	17, 18 and 19, 2012,			: Minnesota Departm	nent of Health	is	
	surveyors of this De	partment's staff, visite the following licensing	ad the		documenting the St Correction Orders u	late Licensing	,	
	were issued. When	corrections are comp	oleted, 🐪		Tag numbers have	been assigne	d to	
	orders and return the	 make a copy of the e original to the Minne h, Division of Compli 	esota 🔚		Minnesota state sta Homes.	tutes/rules for	Nursing	
	partment of Health	n, Division of Compile	ance		7070.4.4.4.4			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SHENATURE

N 44 mile 11/14/12001DATE.

Minnesota Department of Health

Minnesota Department of Health

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112		B. WING _			, 9/2012
	ROVIDER OR SUPPLIER	TATION AND CAR	7505 COL	DRESS, CITY, S JNTRY CLUI VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1		2 000			
	Monitoring, Licensia	ng and Certification F n St, Suite 212, St. Ci			The assigned tag number appear far left column entitled "ID Prefix The state statute/rule number are corresponding text of the state sout of compliance is listed in the "Summary Statement of Deficier column and replaces the "To Coportion of the correction order. column also includes the finding are in violation of the state statut statement, "This Rule is not met evidenced by." Following the sufindings are the Suggested Meth Correction and the Time Period Correction. PLEASE DISREGARD THE HEATHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	Tag." Id the Id	
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehe	nsive	2 565	OTATO LOANGELO.		
		omprehensive plan c I personnel involved t.					
	This MN Requirements	ent is not met as evi	denced				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAIN	OF CORRECTION	IDENTIFICATION NO	JMBEK:	A. BUILDIN	G		
		00112		B. WING _			C 1 9/2012
NAME OF E	PROVIDER OR SUPPLIER	00112	STREET AD	DRESS CITY S	STATE, ZIP CODE	10/1	9/2012
NAIVIL OI F	NOVIDEN ON SUFFEIEN			JNTRY CLU			
GOLDEN	I VALLEY REHABILIT	TATION AND CAR		VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	age 2		2 565			
	review, the facility f provided in accorda of care, related to o	ion, interview and do failed to ensure servi ance with each resid oral hygiene for 1 of 3 the sample for activit	ces were ent's plan 3 residents				
	R29 diagnoses tha dementia.	t included brain injur	y and	ıd			
	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.						
		ated 10/8/12, reveale provide physical assist and as needed.					
		ant care sheet, unda ired assist of one wit					
	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.						
	manager (CM)-F re to use a tooth brus	n 10/18/12, at 12:28 peported that NAs wer h for completion of on oral swab with mouwas edentulous.	re trained ral cares,				
	During interview or	n 10/18/12, at 12:32 ¡	p.m.,				

6899

Minnesota Department of Health

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE S COMPLE	TED
		00112		B. WING _			9/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		NTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3		2 565			
	for R29's oral cares NA-M reported that "toothette" or swab	she did not use an or the morning of 10/1 she typically utilized for R29's oral cares. e no swabs in her roc awer."	8/12. a damp NA-M				
	MOUTH CARE, und to be provided to a The procedure outli be allowed to rinse a soft toothbrush or	dure for ASSISTING dated, identified that resident who was edined that the resident with water or mouther sponge-tipped swale resident's gums, to neeks.	oral cares lentulous. t was to wash and o was to				
	The administrator of system to educate s	THOD OF CORRECT or designee could develop a nate that are providing carten plan of care.	velop a nonitoring				
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty-one				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab -	ADLs	2 920			
	comprehensive reshome must ensure B. a resident who activities of daily livi	is unable to carry ou ing receives the nece n good nutrition, groo	nursing ut essary				
	by: Based on observati	ent is not met as evi on, interview and do	cument				

Minnesota Department of Health

STATE FORM 53FD11 If continuation sheet 4 of 45

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
		00112		B. WING _			0 9/2012
NAME OF F	ROVIDER OR SUPPLIER	00112	STREET ADI	I DRESS, CITY, S	STATE, ZIP CODE	10/1	9/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 4		2 920			
	(ADLs), the necess personal hygiene a additional bathing for	y out activities of dai ary services to maint nd address requests or 3 of 3 residents (R in the sample for act	tain good for R29, R141				
	Findings include:						
	personal hygiene a	t upon staff assistan nd received inadequa by observation on 10	ate oral				
	R29 diagnoses that dementia.	included brain injury	/ and				
	9/20/12, revealed R cognitive skills for demonstrated signs The MDS also indicates the second	m data set (MDS) da 29 had moderately in laily decision making a and symptoms of di cated R29 required ea DLs, including eating	mpaired and elirium. xtensive				
		ited 10/8/12, revealed rovide physical assis and as needed.					
		ant care sheet, undat red assist of one with					
	10/18/12, from 8:10 a.m., nursing assist provided morning c room. After transfe NA-M was observe washcloth to briefly gums. R29 was no	ations were made of a.m. to 9:30 a.m. A tant (NA)-L and NA-Nares to R29 in her restring R29 to her whe d to utilize a dampen wipe R29's upper ar ted to be edentulous No further oral care	at 8:13 M esident eelchair, eed nd lower (without				

Minnesota Department of Health

STATE FORM 53FD11 If continuation sheet 5 of 45

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CAR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G		eted C
SUMMARY STATEMENT OF DEFICIENCIES PREFIX REQUATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REQUATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PREVIDENCIES PREVIDEN			00112				10/	19/2012
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL PLAN OF CORRECTION PRIEFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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, where NA-M was noted to provide R29 mith assistance to eat. At 8:45 a.m., NA-M brought R29 out of the dining 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 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	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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	GOLDEN	I VALLEY REHABILIT	ATION AND CAR					
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
R141 had diagnoses that included dementia.	2 920	provided. R29 was room, where NA-M assistance to eat. R29 out of the dinir wheelchair in the haroom, near the nurs remained in the hal cares provided. During an interview case manager (CM trained to use a too cares, or at a minin wash for a resident added, "I don't think use a washcloth." During interview on NA-M reported that wash cloth for oral typically utilized a dR29's oral cares. Nuse an oral swab for for 10/18/12. NA-M in her room, there was the procedure outling the procedure outling a soft toothbrush or be used to clean the the insides of the cassistance to R141 upon staff for bathin	then brought to the was noted to provid At 8:45 a.m., NA-M to groom and placed lallway outside her rese's station. At 9:30 allway, with no addition of on 10/18/12, at 12:20 are reported that NA to the brush for complete num an oral swab with who was edentulous at it would meet the set at 10/18/12, at 12:32 per she did not typically cares. She reported that shor R29's oral cares the added, "There were were none in her drawdure for ASSISTING dated, identified that resident who was edined that the resident with water or mouther sponge-tipped swal e resident's gums, to heeks. provide frequent bath who was totally deping assistance.	e R29 with brought her sident a.m., R29 nal oral 28 p.m., as were ion of oral th mouth s. NA-F tandard to b.m., a use a wet that she wab for e did not he morning no swabs wer." WITH oral cares dentulous. It was to wash and b was to ongue and hing endent	2 920			

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G		eted C
		00112				10/1	9/2012
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUI VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ige 6		2 920			
	identified R141 was did not reject any a daily living, and req staff member with buring interview on family-B stated R14 his hair being comb had been somethin hair and when she bunch of it fell out. about the hair, but the hair hadn't yet buildicated this was regone a long time wexplained when R1 facility he went near	1 10/16/12, at 12:27 p 11 had gone for a we bed. Family-B explain 1g sticky such as synthesis as synthesis 1g sticky such as synthesis 1g sticky synthesis 1g sticky such as synthesis 1g sticky synthesis 1g sticky synthesis 1g sticky synthesis 1g sticky such as synthesis 1g sticky synth	y impaired, ties of cone co.m. eek without ined there up in the control in the c				
	to be neat, clean ar care plan identified showering and com The nursing assista was to be bathed o The bathing care tr 10/18/12 (20 weeks 12 showers and 2 to (32 days) R141 onloccurred on 7/14/12 tracker report reveals	ant care sheet indican Friday mornings. acker report from 5/3 s) revealed R141 receptaths. From 6/29/12 y received one bed by the control of	y. The stance with ted R141 31/12 to seived only to 7/31/12 bath which the care 2 to				
		· ı 10/18/12, at 9:43 a.	m.,				

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00112		B. WING _			C 1 9/2012
NAME OF F	ROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	19/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		NTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 7		2 920			
	frequently did well in cooperative. RN-D	N)-D indicated R141 n the shower and wa was unable to provid hy R141 was not bat	s e an				
	nursing assistant (N showers to R141 or and confirmed R14 shower. NA-G reme on 10/11/12, becau	10/18/12, at 10:15 at IA)-G recalled provide casionally since adm 1 was cooperative in embered the last shouse of the syrup in R1 o explain why R141 howers.	ling nission the wer given 41's hair.				
		provide assistance wing to R14 who reque					
	R14 was admitted that included morbid	o the facility with a did obesity.	iagnosis				
	worksheet dated 5/3 somewhat importar a bath, shower or s identified R14 prefe or sponge bath. The 8/22/12, identified the	imum Data Set (MDS 26/12, identified it want for R14 to choose of ponge bath. The formal erred a shower over a e quarterly MDS date that R14 was cognitive sive assist of two states	between m a tub, bed ed ely intact				
	The 1st Floor Break received a bath on	Sheet indicated R1/10/13/12.	4				
	only get one showe every day but even would be okay." R1	3:23 a.m., R14 report r a week. I would like two or three times a 14 went on to state, " ause I don't get more	e one week I get a				

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN		(X3) DATE S COMPLE	TED
		00112		B. WING _			9/2012
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		NTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 8		2 920			
	every day. At home day." R14 stated sl who helped her tak wanted a bath more	sweat. They wash you I always showered on the told the nursing are a bath last Saturdate frequently. During the dor was noted on Ro	every ssistant by that she he				
	still like more show up because of my f humiliates me. And	7 p.m. R14 stated, "I ers. Right now I get y olds. It's so strong it I don't care what the doesn't help, I need t	/east build just ey say	ast build st say			
	-K stated R14 recei Saturdays. NA-K re	3 a.m. nursing assistived one bath a week ported if a resident rewer a week the staff	on ` ´ equested				
	administrator (TMA	02 a.m. trained med .)-A stated he worked eported R14 liked to	d on				
	received a shower of reported she also to 10/17/12, that she was frequently. R14 state on 10/17/12, but the time, "which was ur were busy". R14 fur many times she was a week because she stated no one has ewhether or not they shower a week. R1	23 p.m. R14 stated son 10/13/12, by NA-Cold NA-B on the ever wanted a shower mosted she requested a se staff did not have enderstandable becauther stated she told inted a second or thing felt like she smelle ever gotten back to he could provide more 4 verified she had no manager, but stated	C. R14 ning of re shower nough se they staff rd shower d. R14 er on than one				

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE S COMPL	ETED
		00112		B. WING _			0 9/2012
NAME OF F	ROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	3/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 920	told enough people On 10/18/12, at 12: requested a shower NA-B stated she was staff did not have the night of 10/17/12. Nalmost every night is reported if R14 wars second shower she nurse (RN)-A. NA-E request to RN-A be process here. On 10/18/12, at 2:1 had not informed his showers more frequent show them into the scheen have some issues wand understood her showered more free On 10/18/12, at 2:3 helped R14 with he verified R14 told he shower every other NA-D stated she tols she only worked the not on duty. NA-D was to tell the resid	why aren't they telling why aren't they telling as scheduled for Saturne to give her a show the stated R14 calls requesting a shower at the should talk to the reason as stated he did not be cause that was not the stated he did not be cause that was not the should talk to the reason as stated he did not be cause that was not the stated show if a resident requirer so the facility contains as the facility contains and the show if a resident requirer so the facility contains and the shower on 10/13/12 are she would like to the day or at least twice and R14 to tell RN-A be weekend shift and facility's pent to let the RN-A contains and the should the facility's pent to let the RN-A contains and the should the should the should the should be weekend shift and the should the should be the RN-A contains and the should be should like to the should be should like to the should be should like to the should be shoul	med R14 17/12. urday and wer the s out NA-B for a gistered ing R14's he ed staff o take staff uests uld work 14 did skin folds ag to be ed she 2. NA-D ake a a week. ecause RN-A was rocess ase	2 920	DEFICIENCY		
	themselves. SUGGESTED MET The DON or design as necessary the poregarding the need	THOD FOR CORRECTED THOD FOR CORRECTED THOD FOR CORRECTED THOSE THO	CTION: nd revise es Activities				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
		00112		B. WING _			C 9/2012
NAME OF P	ROVIDER OR SUPPLIER	00112	STREET ADI	I DRESS, CITY, S	STATE, ZIP CODE	10/1	9/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 10		2 920			
	policies and proced documentation. The	all appropriate staff of lures and importance to DON or designee (so Il residents are recei appriate care.	e of s) could				
	TIME PERIOD FOR One (21) Days.	R CORRECTION: T	wenty				
2 930	MN Rule 4658.0525 Nasogastric, Gastro	5 Subp. 7 B. Rehab - ostomy tubes		2 930			
	and feeding syringes. Based or	ric tubes, gastrostom n the comprehensive sing home must ensu	eresident				
	gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab	who is fed by a nasog r feeding syringe rec ent and services to pro- nia, diarrhea, vomiting olic abnormalities, ar licers and to restore, eding function.	eives the revent g, nd				
	by: Based on observati review, the facility for tube placement was and nutritional supp resident (R262) rev administration via a Additionally, the face medications and nu	ent is not met as evi- on, interview and doc ailed to ensure gastro s checked prior to mo elements given for 1 of iewed during medical gastrostomy tube. cility failed to ensure to itritional feedings were ding to the facility pool	cument ostomy edication of 1 ition that re				

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	
		00112		B. WING			19/2012
NAME OF F	PROVIDER OR SUPPLIER	•	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	•	
GOLDEN	N VALLEY REHABILIT	TATION AND CAR		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 930	Findings include: On 10/18/12, at 8:2 -C was observed to nutritional supplem check placement o addition, RN-C use fluids, which include nutritional supplem the gastrostomy tule R262's physician of centimeters (cc) of can) be administered tube (g-tube) four time water before, during the gastrostomy tule water before, during the graph of the g	20 a.m. registered nub administer fluids and ents to R262, and diff the gastrostomy tuled a large syringe to a ed water and Jevity ent and pushed the labe. Index specified that 2 free water and Jevity ed through the gastroimes per day with 50 g and after the feeding and after the feeding ed forgotten to check ed facility use gravity to the control of the gravity to the control of the gravity to the gravity	ad d not oe. In administer 1.5 liquids into 250 cubic y 1.5 (1 ostomy occ of ng. 3:30 a.m. the orted that o od other reported licy	2 930			
	10/18/12, at 2:13 p expected all nursing fluid/medication via method for administ placement of the g- liquid or medication copy of pages from as the facility's producenteral (tube) feeding directed staff to che gastrostomy tube p liquid and if the star syringe would be fill	ses (DON) was interm. She reported shigh staff who administed the g-tube to use the stration and to check the prior to introduct the Lippincott Nursicedure for administratings. The provided deck placement of the porior to administration of the grown and allow fluid to the stomach by grown.	e ered any e gravity cing any notocopy ng Manual ation of document en of any ge, the oflow				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` '	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		00112		A. BUILDING B. WING			9/ 2012
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	10/1	0,2012
	I VALLEY REHABILIT	ATION AND CAR	7505 COU	NTRY CLUE VALLEY, MN	3 DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 930	Continued From pa	ge 12		2 930			
	Director of Nursing the policies and pro of medications and Gastrostomy Tube a staff training regard medications and nu Ongoing audits of the staff could be performant	THOD OF CORRECT or her designee could be designee could provide or and could provide or ling the administration through the Gine procedure for all limmed to ensure compared to the consure consumer c	Id review inistration ended in the inistration of the idea of the				
21100	MN Rule 4658.0650 Storage of Perishab	0 Subp. 5 Food Supp ole food	olies;	21100			
	perishable food mu washable, corrosion	of perishable food. A st be stored off the fl n-resistant shelving u and at temperatures spoilage.	oor on ınder				
	by: Based on observatireview the facility fatemperatures that he to minimize the risk	ent is not met as evi- tion, interview and doc ailed to monitor refrig- neld potentially hazard of food borne illness affect 74 of 153 resi emental snacks.	cument erator dous food s. This				
	Findings include:						
	the last five months have a system in pl	ripment Temperature s identified the facility ace to ensure all refronal supplement refrig d for proper holding	did not rigerators,				

6899

Minnesota Department of Health STATE FORM

53FD11 If continuation sheet 13 of 45

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S		
		00112		B. WING _			9/2012	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		0,2012	
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		UNTRY CLUB DRIVE I VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
21100	During the initial kit p.m. the dietary madietitian (RD) were thermometer in the refrigerator. DM corpotentially hazardor assortment of deli risalad, hard boiled etc. On 10/15/12, at 1:3 (DM) confirmed the temperature log indicates and a thermomensure potentially his within the proper rabacterial growth and the facility's Refriguence of the laws not a thermomensure potentially his within the proper rabacterial growth and the facility's Refriguence of the laws not a thermomensure potentially his within the proper rabacterial growth and the facility's Refriguence of the facility's Refriguence of the facility's Refriguence of the facility of the fa	chen tour on 10/15/1 nager (DM) and regi unable to locate a nutritional suppleme nfirmed this refrigera us foods such as an meat, cheese, yogurt	ental	21100	DEFICIENCY)			
	are maintained. TIME PERIOD FOR days.	R CORRECTION: S	even (7)					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00112		A. BUILDIN B. WING _		10/1	9/ 2012		
NAME OF P	PROVIDER OR SUPPLIER	00112	STREET ADI	DRESS CITY S	STATE, ZIP CODE	10/1	9/2012		
	I VALLEY REHABILIT	ATION AND CAR	7505 COU	DUNTRY CLUB DRIVE N VALLEY, MN 55427					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
21470	Continued From pa	ige 14		21470					
21470	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.			21470					
	by: Based on observation review, the facility facommunicate with a three residents (R2)	a family the goals for 62) reviewed for soci to expectations of ca	cument one of ial						
	Findings include:								
		ed concerns regarding eel their requests wer							

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	X3) DATE SURVEY COMPLETED C
00112 B. WING	10/19/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN VALLEY REHABILITATION AND CAR 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	D BE COMPLETE
21470 Continued From page 15 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 so reported the felt the	

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU	NUMBER: COMPLET		ETED		
		00112		B. WING _			C
NAME OF		00112	CTDEET AD	DDECC CITY O	STATE, ZIP CODE	10/	19/2012
NAME OF	PROVIDER OR SUPPLIER			JNTRY CLUE			
GOLDE	N VALLEY REHABILIT	TATION AND CAR		VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21470	Continued From pa	age 16		21470			
	his mother's needs staff were making of care without family knowledge of her in A review of the me on the front of the on the family stated that a earlier, a nurse car to insert a catheter did not know the rawere told the direct them to do so. The during the interview catheter upon her aupon recommendal examined R262, it R262's son stated mother and did not The family met with after the discussion resident's urologist. The family stated the family stated the to insert the catheter the family also republicated a nurse afor Tuberculosis) edisagreed with the given to R262. The Mantoux's shortly a facility and they felting the care of the or the family and they felting the care without the given to R262. The Mantoux's shortly a facility and they felting the care without the given to R262.	dical record noted a chart which indicated ested that all change e discussed with the won 10/16/12, at 8:3 pproximately four to ne into the room, and When questioned, tionale for this, other or of nurses (DON) e resident's son report that his mother had admission to the facition of a urologist, whad been discontinuating was a victory for want a catheter resent the DON on 10/14/10, the DON contacted and the order was recovered that is them prior to getting er.	facility mother's dequate notation it that es in em. 44 a.m. the five days d prepared the nurse r than they had order orted d a lity and ho had ed. his started. 12, and d the escinded. this was an order erview on ey oux (a test engly it not be ed two o the g was				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
		00112		B. WING _			C 1 9/2012
NAME OF P	ROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	9/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUI VALLEY, MI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21470	Continued From pa	ued From page 17		21470			
	done and should not administered. During an observative registered nurse (Registered nurse (Registered not administering insolved sugar was 11 allow her to do so a sugar results were received a laboratory (lab) stresident's door and intentions to draw be testing that was ord the husband asked that was to be doned discuss it with the head that	of be repeated but the store on 10/18/12, at 7 N)-C was observed to insulin syringe and 262's husband of her sulin to the resident a 9. R262's husband and stated her (R262's within a normal range any insulin. During the aff member came to informed the husbardlood on R262 to complered by the physicial for clarification of the stand what test was to was unable to spect test. R262's husbard what test was to was unable to spect test. R262's husbard and verified R262'n resident care and find repositioning has not show that the familing assistants documed as a single stand of the familing assistants documed and the familing assistants documed as all the nursing staff.	:45 a.m. to enter intention s her refused to) "blood e" and hat time, the hd of his hplete lab n. When e lab test fused to ember left C s ordered ify the hd eted. ed on 2's family nent in a I and the s of ally the ed on 2's				
	10/18/12, at 8:30 a. husband had been day. She indicated		2's flier in the led about				

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	TION (X3) DATE SUI COMPLET	
		00112		B. WING _			19/2012
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u>'</u>	
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21470	assessed the resideresident in any response superficial suctioning minimal return. She was upset about blesteeve and RN-C the blood." She indicated husband and family was surprised by his to a concerns. She reported that she here in the resident's conditional determined R262 we contacted R262's proncern regarding requested the phys The DON indicated family's decision to testing at times, which did not make any in conversations held the family's expectation for R262. An interview with the (SW)-A was complead. She reported family concerns, every stand up" meetings who conditions are discussions to the discussions of the discussions of the discussions of the superfined family concerns, every stand up the discussions of the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family concerns, every stand up the discussions of the superfined family the discussions of the superfined family the discussions of the superfined family the supe	ent and did not find to irratory distress but on gof the tracheostor e also reported that lood he observed on nought "he was afraicted that generally R27 are generally coopers reaction earlier too reviewed on 10/18/12, and the was aware of famorted R262's had been was not needed as ibe the administration nunization record. Shad completed a character of the was of aware of the was of care and treated on 10/19/12, at not being aware of the was of resident of the was of resident of the was of aware of the was of aware of the was of care and the was of aware of the was of care and the was of aware of the was of care and the was of aware of th	did my with husband R262's d of 662's erative and day. at 12:30 ily's en given a s staff had n of the ne also t audit of d had nen sed down and catheter. If the nd lab The DON nere were gards to eatment pervisor 11:04 R262's ded "triage ents orted that nusband,	21470			

6899

Minnesota Department of Health

I .	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00112		B. WING _			C 9/2012
NAME OF P	PROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/	0/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUI Valley, Mi			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21470		262's husband on 10		21470			
	expected R262 to le indicated R262's fa difficulty accepting happen and potenti verified social servi family on a regular condition or offered family to aid them vecondition and progreservices had not be for the family's required.	ad told her that family eave the facility walk mily seemed to be hathe probably this wou ally R262 was terming the sais to discuss her additional services to the acceptance of the costs. She also reported involved with advicests with nursing staural issues presented.	ing. She aving uld not nal. She g with the medical to the of R262 rted social rocating aff and				
	The Social Services policies and proced are assisted with in	THOD FOR CORRECT SUPERVISOR COULD IN THE PROPERTY COULD IN THE PROPERTY COULD FOR THE PROPERTY COUNTY CO	eview residents ring their				
	TIME PERIOD FOR days.	R CORRECTION: TI	hirty (30)				

6899

Minnesota Department of Health

			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112		A. BUILDIN B. WING _		10/1	9/ 2012
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUI VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	E ACTION SHOULD BE D TO THE APPROPRIATE	
21520	Continued From pa	ge 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.			21520			
	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.						
		egimen. "Drug regimed and over-the-coundent is taking.					
	by: Based on observati review, the facility factories were secu medications and bir residents (R292, R270), reviewed for	ent is not met as evi- ion, interview and do ailed to ensure pharr red, including routine ologicals as ordered 161, R284, R51, R30 r missed medication not being available f	cument maceutical e for 6 of 9 and doses				
	Findings include:						
		administered timely on being unavailable					
		to the facility on 9/2 g closed fractures of					

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE S COMPL	ETED
		00112		B. WING _			C 0/2012
NAME OF F		00112	CTDEET ADI	DESS CITY S	STATE, ZIP CODE	10/1	9/2012
NAME OF P	ROVIDER OR SUPPLIER			, ,	,		
GOLDEN	I VALLEY REHABILIT	TATION AND CAR		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)		
21520	Continued From pa	ige 21		21520			
	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.						
	to approach licenses stated, "Have you get LPN-R replied, "No loudly and shake he this was the third time of her medication. facility's process for pharmacy and whe medications in time ordered. LPN-R vermedications "at time resident medication residents had to mit ordered by their photon the facility's process to remove the label was getting close to	225 p.m., R292 was ded practical nurse (Ligot my Percocet yet?," R292 was noted to er head. R292 then me that the facility had LPN-R was asked a rordering medication ther they had difficulty to administer them erified the facility had es" and had not recens timely, to the point iss doses of medications for refilling medication or running out." The light responses to the medication or running out."	PN)-R and " When o sigh stated that ad run out bout the n from the ty getting as run out of eived that ions rted that tion was "when it abel was				
	then to be placed of to the pharmacy. It medication was new were to call the pharmacy order of the medical had typically been a medication order from hours of the request had been occasion medication label to when she arrived for days later," the medicand the resident had	anto a sheet of paper IPN-R reported that is eded right away, the armacy and request a ation. LPN-R reported by the pharmacy with the pharmacy for reformer her next shift "a condication had still not a did missed several do ation not being available.	and faxed f a nurses a stat d that she thin two hat there ed a fill and puple of arrived ses as a				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		00112		B. WING _			19/2012
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u>'</u>	
GOLDEN	I VALLEY REHABILIT	TATION AND CAR		JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21520	LPN-R reported that situations, she wou pharmacy and rece hours. LPN-R reported that the re-fill date indicated to the pharmacy and need to be sentindicated that she is medication refills to receive the received order for R292's Performance of the medication refills to receive the reported that at 7:00 a.m. and had 11:00 a.m., when so the medication. eight on a scale of awful throbbing described her pain area, down her arm reported pain in he R292 stated, "It is usefor her pain medicated to 10 (on a scale of as needed Percoce post administration." Review of medication. Review of medication. Review of medication.	at when she encount ald call in a stat order lived the medication orted that she was not occurring, other than on the label may have armacy that the medit until that date. LPN and reported this proto the unit care manage that she was awaiting ercocet. You on 10/17/12, at 12:4 she last received he had requested anothe she was told the facil R292 identified her pone to 10. R292 state aching horrible." as from her left shown and into her hand. It right knee to quadrunacceptable," having a state of the state of the contraction and into her hand.	to the within two of sure in to guess we ication did N-R blem with ger (CM) ing a stat. 40 p.m., er Percocet in dose at ity was out oain as an ited, "It's R292 ulder/ neck She also iceps. g to wait. in 10/1/12 atings of 8 stration of if 1 to 4 icet. cord in two did not contain the d	21520			
	LPN-R on 10/17/12	2, at 3:00 p.m. read, besident asked for mo	"At about				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1	(1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		A. BUILDIN		(X3) DATE S COMPLE	
	00112		B. WING _			9/2012
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN VALLEY REHABILITAT	TION AND CAR		NTRY CLUE /ALLEY, MN			
PREFIX (EACH DEFICIENCY MU	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
pills, rates pain as 8/10 called to pharmacy to 1st run, hopefully stat. when writer told her th but could take up to 4 Resident [at] 12 Noon writer asking if pills ha was still very upset, who given, but resident der pain meds arrived, given, but resident der pain med arrived, given, but resident der pain are selected to produced by the pituitation der pain med arrived, given, but resident der pain are selected arrived, given, but resident der pain arrived, given, but resident land arriv	10, at the time pills get them to come a Resident was vent the pills were of [four] hours to get in [12:00 p.m.] re-apave arrived yet rewriter offered Tylend and the pills were 2, relief noted a were missed for Rebeing available for inded hypopituitarism of hormones normary gland). 2d 9/29/12, revealed and 9/29/12, revealed and for genotropin was ment of growth horror or 9/1/12 to 9/30/12 ot administered the aduled, at 8:00 a.m., 9/4/12, 9/5/12 and Error Report dated to R161 from 9/1/2 or a delay in insurance and dministered timely dministered timely	out on ry upset in the way here.' proached sident of to be 0 p.m.] at 1500 at 161 due in ally displaying single tropin 12 ince in result of for R284	21520			

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A.			(X3) DATE S COMPLE	
		00112		B. WING _			9/2012
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		NTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21520	Continued From pa	ge 24		21520			
	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).						
	the facility nurses we medication that he lunch. R284 report don't have the medicated that help break down his medication before help that served in the facility	10 p.m., R284 reporterer refusing to admineeded in order to eaded, "They're telling rication that they're he needed the medias food and he had to ne ate or he would go lunch was scheduled at 11:30 a.m. and he he had not received	nister a at his me they out of it." cation to take the et sick. d to be he had to				
	LPN-R verified that R284's PhosLo at 1 looked in her medic there were no Phos medication bubble pre-packaged medi reported that once shosLo pills left for	10/17/12, at 12:15 p she was going to ad 1:00 a.m., but when cation cart, she notice Lo pills left in R284's pack (pre-set up/ cation punch card). she noticed there we R284, she called the	minister she ed that s LPN-R ire no				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLI	(X3) DATE SURVEY COMPLETED	
		00112		B. WING _			C 9/2012
NAME OF F	ROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	9/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETE DATE	
21520	Continued From page 25			21520			
	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.						
	LPN-R was noted to the second floor dir	uring observation on 10/17/12, at 12:30 p.m., PN-R was noted to administer R284's PhosLo in e second floor dining room. R284 was then erved his lunch, an hour after other residents ad 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.						
	revealed Fragmin w	for 10/1/12 to 10/17/ vas not administered note indicating the me	to R51				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 00112			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C		
		00112	T			10/	19/2012
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUI VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21520	medication error. Fithis missed dose of Medication was not administration due available. R30 diagnoses incl Physician orders dawas to receive an indecanoate (Prolixin weeks (Monday ove Prolixin Decanoate antipsychotic for indecanoate antipsychotic for indecanoate (Prolixin Decanoate antipsychotic for indecanoate decanoate antipsychotic for indecanoate decanoate	R51's physician was in 10/17/12, at 12:00 to offered to R30 for tito the medication not uded paranoid schiz ated 10/3/12, revealed pection of fluphenazin Decanoate) 50 mg ernight shift) for schiwas indicated as a Idividuals with chronical for 10/1/12 to 10/17 not administered the ate as scheduled during the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertion of the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertion of the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertion of the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertion of the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertion of the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertional transfer and the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertional transfer and the morning of 10/9/15 is noted as, "Not avair adverse reactions woo's physician was propertional transfer and tra	p.m. mely t being ophrenia. ed R30 ine every two zophrenia. ong-acting c 7/12, injection ing the ed 10/9/12, oate was 12. The ilable for were noted omptly 10/9/12 /9/12, but t notes delivered tion	21520			
	Medication doses v	vere missed for R27	0 due to				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CAR ((A) ID PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 administered her daily 20 mg dose of Celexa on 10/14/12 and 10/17/12. 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 propt also indicated that only a half dose was administered as scheduled at 8:00 a.m. 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.,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CAR (X4) ID PREFIX TAG CONTINUED TO THE APPROPRIATE CONTINUE			IDENTIFICATION NO	WIDER.		G		С
GOLDEN VALLEY REHABILITATION AND CAR 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MM 55427 TAG SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 as scheduled at 8:00 a.m. on 10/14/12 and 10/17/12. 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.,			00112		B. WING _			
(X4) ID PREFIX TAG (X4) ID PREFIX TAG (X4) ID PREFIX TAG (X5) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X6) ID PREFIX TAG (X6) ID PREFIX TAG (X7) ID PREFIX TAG (X8) ID PREFIX TAG (X9) ID PREFIX TAG (ACC) ID PREFIX TAG (AC	NAME OF F	PROVIDER OR SUPPLIER	•	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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.,	GOLDEN	N VALLEY REHABILIT	TATION AND CAR					
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 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.,	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY	/ FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
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	21520	the medication not administration. R270 diagnoses inc. Physician orders da to receive citalopra depression, via her. Review of the MAR revealed R270 was mg dose of Celexa The MAR also indicadministered on 10. Review of Medicati 10/17/12, revealed not administered as 10/14/12 and 10/17 that only a half dos 10/16/12. The reportaken to prevent sin nurses to report mi was notified of thesat 6:00 p.m. During interview or CM-E verified the for prescriptions from that she had taught least 24 hours ahe needed, by removing medication and fax She reported she had call the pharmacy fitme for administrative reported, to her known and call the pharmacy fitme for administrative ported, to her known and call the pharmacy fitme for administrative ported, to her known and call the pharmacy fitme for administrative ported, to her known and call the pharmacy fitme for administrative ported, to her known and call the pharmacy for the pharmacy for administrative ported, to her known and call the pharmacy for administrative ported, to her known and call the pharmacy for administrative ported, to her known and call the pharmacy for administrative ported, to her known and call the pharmacy for administrative ported, to her known and call the pharmacy for administrative ported.	being available for cluded depression. ated 9/1/12 revealed m (Celexa) 20 mg day feeding tube. It for 10/1/12 through a not administered he on 10/14/12 and 10/16/12. The report date the medication Celes scheduled at 8:00 at 7/12. The report also be was administered for noted that precaumilar errors included sort noted that precauming the label from the the pharmacy. She is the nurses to request ad of the time they was a day of the label from the ing the label to the pharmacy in the label to the pharmacy of the label to the pharmacy.	aily for 10/17/12, er daily 20 /17/12. f dose was a.m. on o indicated on titions educating s physician 10/17/12, o.m., refilling reported est refills at vere charmacy. nurses to ordered ar. CM-E othe facility	21520			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 '	PLE CONSTRUCTION	(X3) DATE S COMPLE			
				A. BUILDING B. WING		- (C	
		00112		D. WING _		10/1	9/2012	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CAR		UNTRY CLUB DRIVE I VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21520	Continued From pa	ge 28		21520				
	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.,							

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 00113			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G		eted C		
NAME OF S		00112	QTDEET ADI		STATE ZID CODE		19/2012	
	ROVIDER OR SUPPLIER I VALLEY REHABILIT	TATION AND CAR	7505 COL	NDDRESS, CITY, STATE, ZIP CODE DUNTRY CLUB DRIVE N VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21520	medication was not the nurse would cin MAR, write on the base medication was not supervisor so follow physician could be The facility's Medic revised 7/10, instrumedication assistar any dose omission back of the MAR. acceptable to omit medication not ava Remove a dose from Emergency Kit or comparmacist and recompliance. Suggested Method administrator or despharmacy policy and the delivery of medication the medication of the medication or despharmacy policy and the delivery of medication the medication of the	t available for adminicle the dose missed back of the MAR that available and notify vup could occur and notified. ation Administration cted licensed nurses of the policy noted, "It a dose by indicating ilable from pharmacy or puest medication to be possible]. If the medict the physician for the policy noted in the physician for the policy noted in the physician for the possible of Correction: The signee could review and revise systems to ications for each rested medications are ride training for pharmacy arding these system to assure R CORRECTION: The system to a system to	on the t the their d their d their d the Procedure s and/ or eason for on the is not 'NA' for y. on-call be sent dication is further the improve ident and not stored macy staff is. re	21520				
21530	A. The drug regim reviewed at least m currently licensed b This review must be	O A.B.C Drug Regimen of each resident nonthly by a pharmac by the Board of Pharmed done in accordanc State Operations Ma	must be cist macy. e with	21530				

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			A. BUILDIN		(X3) DATE S COMPLI			
		00112		B. WING _	·····		9/2012		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE					
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		NTRY CLUE VALLEY, MI					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE YMUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ΓΙΟΝ SHOULD BE ΓΗΕ APPROPRIATE	(X5) COMPLETE DATE		
21530	Surveyor Procedures for Pharmaceutical Service			21530					
	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								
	available through th system. It is not su B. The pharma	ne Minitex interlibrary bject to frequent cha cist must report any	y loan nge.						
	and the attending p must be acted upor	director of nursing se hysician, and these r n by the time of the n coner, if indicated by	eports ext						
	pharmacist. For pu upon" means the ac report and the signi	rposes of this part, " cceptance or rejectio ng or initialing by the	acted n of the director						
	C. If the attend with the pharmacist	and the attending ph ing physician does no 's recommendation, te justification, and the	ot concur or does						
	pharmacist believed being adversely afforefer the matter to t	s the resident's qualit ected, the pharmacis he medical director f	ty of life is t must or review						
	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.								
	by:	ent is not met as evi							
	facility failed to ade	and document review quately identify, asse- cations to evaluate the	ess and						

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			A. BUILDIN		COMPL	(X3) DATE SURVEY COMPLETED			
		00112		B. WING _			9/2012		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DDRESS, CITY, STATE, ZIP CODE					
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUB VALLEY, MI					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE YMUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
21530	Continued From page 31			21530					
	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.								
	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.								
	indicated R31 had three times daily as trazodone 25 mg at addition, R31 received	an's order, dated 10/ been receiving xanax needed (PRN) for a bedtime PRN for sle yed scheduled doses every morning and tra for anxiety.	0.5 mg nxiety and eep. In of xanax						
	and licensed social February, once in A July and once in Au documentation lack	r provided the psychic worker visits to R31 april, four times in Ma agust 2012), the aed a comprehensive specific anxious beh	(twice in ly, once in						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM				PLE CONSTRUCTION G	COMPL	(X3) DATE SURVEY COMPLETED C		
		00112		B. WING _	·	10/19/2012		
NAME OF F	PROVIDER OR SUPPLIER	00112	STREET AD	DRESS, CITY, S	STATE. ZIP CODE	10/1	13/2012	
	VALLEY REHABILIT	TATION AND CAR	7505 COL	DUNTRY CLUB DRIVE N 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21530	sleep and awake p staff's documentati panic/anxious episc xanax and trazodor. Medication Adminis July 2012 to preser R31 used PRN xar in August, 21 times in October 2012. The appropriate monito including specific a exhibited by R31, a interventions attern interventions. In accommonitor all appropriate worthostatic blood prodiary," record indicating his in May (5/11 pattern, otherwise, facility staff monitor patterns to justify the On 10/18/12, at 1:00 Manager, Registern had diagnosis of ar paranoid schizophri	atterns and review o on on R31's specific odes to justify the us	de of PRN AR) from d indicated 24 times 11 times used four in ked ations, ors gical f these d not ociated hiple eleep only three 31's sleep hice the ke for sleep. I., Unit ted R31 and and had	21530	DEFICIENCY			
	years. RN-B indicate explosive behaviors nursing staff on hor for PRN medication staff documented in care tracker (compadministered PRN the progress notes	ated the resident did s, rather would alert w she felt and would ns. RN-B added, the n the progress notes uterized documental medications. After rand the care tracked appropriate monitoring	not exhibit the request e nursing and in tion) when eviewing r data,					

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		00112		B. WING _	-	10/19	9/2012	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CAR		INTRY CLUI VALLEY, MI				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETE DATE		
21530	Continued From page 33			21530				
	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 FOF (21) days.	R CORRECTION: To	wenty one					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unne	ecessary	21535				
	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							

Minnesota Department of Health

STATE FORM 53FD11 If continuation sheet 34 of 45

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED	
		00112		B. WING _			9/ 2012
NAME OF P	ROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	3/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21535	Continued From page 34			21535			
	Long-Term Care Fa Department of Heal Health Care Finance This standard is incontavailable through the system and the Sta subject to frequent This MN Requirement	Guidance to Survey acilities, published by acilities, published by acilities, published by the and Human Serving Administration, Acorporated by reference Minitex interlibrary te Law Library. It is change.	the ices, pril 1992. ce. It is loan not				
	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.						

6899

Minnesota Department of Health

A. BUILDING	_
B WING	C 0/19/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	0/10/2012
GOLDEN VALLEY REHABILITATION AND CAR 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG DEFICIENCY)	(X5) COMPLETE DATE
21535 Continued From page 35 21535	
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 trimes 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 diany," record indicated staff monitored four nights in May (6/11, 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.	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLI	(X3) DATE SURVEY COMPLETED	
		00112		B. WING _			0 9/2012
NAME OF F	ROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	3/2012
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21535	Continued From page 36			21535			
	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.						

6899

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							C 10/19/2012
NAME OF F					STATE, ZIP CODE	10/1	13/2012
			JNTRY CLUI VALLEY, MI				
(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) (COM		
21535	Continued From pa	ige 37		21535			
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty-one				
21620	MN Rule 4658.134	5 Labeling of Drugs		21620			
	Drugs used in the nursing home must be labeled in accordance with part 6800.6300.						
	by: Based on observati review the facility fa medications were of medications were reseven medication of storage. The facilit substances locked personnel only and	ent is not met as evicent, interview and do ailed to ensure open and the administered for metarts reviewed for metarts reviewed for metarts reviewed to keep and accessible to at stored medications a refrigerators that we ation storage.	d expired one of edication controlled uthorized with food				
	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.						
	recommended stor. Byetta Pen was to I 30 days, the pen sh there was some me Registered nurse (I	ylin Pharmaceuticals age guidelines indicate be used for only 30 conculd be discarded edicine left in the per RN)-A verified no opold that it should have di.	ated the days. After even if n. en date				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		00112		B. WING _			19/2012
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
				INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG				ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
21620	Continued From pa	ige 38		21620			
	cart on 10/15/12, at blood thinning med clots) was found in vial had an expiration. The heparin had lass morning on 10/15/1 the expiration date. During continued remedication cart, two (an inhaler used to obstructive pulmon bottom drawer open opened date labels Advair inhalers wer and each nurse was	ion of the first floor in t 2:00 p.m., a vial of ication used to prevente top drawer. The on date of Septembers been administered 12, at 8:00 a.m., 15 deview of the first floor of dispensers of Advantage as the many disease) were found; however, the many disease were found; however, the many disease when the top be dated when the top iration and opened of the top iration and opened opened of the top iration and opened of the top iration and opened o	Heparin (a ent blood multi-use er 2012. It that lays past or air Diskus ronic und in the edication tated opened ecking the				
	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.						
	the third floor deme p.m., a multi dose v controlled substant found to be stored Also in the door wa (a medication used tuberculosis infection open date. License immediately remov placed it in the lock locked medication	the unlocked refrige entia unit on 10/15/12 vial of Ativan (a sche ce anti-anxiety medic on the top shelf of the sa multi dose vial of to aid in the diagnosion) which did not have d practical nurse (LF ed the vial of Ativan ed refrigerator in the room. LPN-A stated to be thrown out beca	2, at 5:23 dule IV cation) was e door. f Tubresol sis of a ve an PN)-A and e third floor the				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		00112		B. WING _			9/2012
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUI Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21620	been opened and sused for food storage Ativan should not hunlocked refrigerated. Review of the facility Date of Medications Needles policy date not to be stored in the general storage are biologicals are storage are biologicals are storage and biologicals are storage are biological	tored in a refrigerator ge. LPN-A further state ave been stored in the process. Storage and Express, Biologicals, Syring at 5/10/10, revealed the refrigerator, freezes where medication are expired date of the storage of the policy also in the process of the policy indicated are and that facility states and that facility states and that facility states are on the medication has a she opened. Finally, they should ensure Scheles are only accessible armacy and medicated by facility. Cation administration of the licensed nurse and the licensed nurse and the prior to the prior to 10/29/12 at 12:30 p.	iration es and food is eer, or n and ndicated on the her to the ed the lier es for ff should on ortened e policy edule II-V ole to il	21620	DEFICIENCY)		
	consulting pharmac Diskus, Byetta and have been dated wh pharmacist also ver Heparin should hav	sist confirmed the Ad Tubresol medication hen opened. Consult ified the expired vial e been discarded an use past the expiration	vair is should ting of id should				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C		
		00112	0.70557.405	DEGG OFTY	774TE 710 000E	10/1	9/2012
7505 COU				INTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21620	The director of nurs development and in procedures to ensu labeled and stored nursing or her design	rge 40 THOD OF CORRECT sing or her designee inplement policies and ire that medications a appropriately. The di gnee could then month	could ad are lirector of aitor the	21620			
21800	procedures. TIME PERIOD FOR days	R CORRECTION: To 651 Subd. 4 Patients	hirty (30)	21800			
	Subd. 4. Informare residents shall, at a are legal rights for stay at the facility of treatment and maint that these are described written statement or responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organd accommodations shall communication impropriate a language of facility policies, insplocal health authorite the written statement to patients, resident	tion about rights. Pandmission, be told that their protection during their protection during throughout their contenance in the comparibed in an accompanited in this section. In this section, witted to residential panders and the content of the c	at there ag their urse of nunity and nying s and In the programs en of a release as a 2, and bers of de s in se with who Current ate and anation of available their				

Minnesota Department of Health

STATE FORM 53FD11 If continuation sheet 41 of 45

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
	00112		B. WING			9/2012	
NAME OF F	ROVIDER OR SUPPLIER	<u>.</u>	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
001.054	LVALLEV DELIADULT	ATION AND OAD	7505 COL	JNTRY CLUB	DRIVE		
GOLDEN	I VALLEY REHABILIT	ATION AND CAR	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)		
21800	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.			21800			
	diagnoses that incluamputation. R128 s 5/8/12. A review of R128's Assistant Progress revealed, "The pt [phome with Daughter Progress Report and 5/7/12, indicated Rephysical therapy on remaining. R128's medical reconst provided the Cell Medicaid Services of R128 or his legal reexpedited review of termination of all M coverage reasons. During interview on minimum data set (to the facility on 4/6, uded an above the known and the known and the physical therapy (PT Update notes, dated patient] may D/C [distraffective 5/8/12.". In Discharge Summa 128 would be dischated 5/7/12, with benefit ord revealed the facility and the presentative of his reservice termination edicare Part A service 10/18/12, at 2:25 p. MDS) coordinator very providing liability not the provided liability not the providing liability not the providin	nee ome on 1 5/4/12, charge] The PT ary, dated rged from days ility had and o inform ight to an following ces for m., the erified she				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		00112		B. WING _			9/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CAR		INTRY CLUE Valley, Mi			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	(X5) COMPLETE DATE	
21800	Continued From pa	ge 42		21800			
	REGULATORY OR LSC IDENTIFYING INFORMATION)						
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients	s &	21805			
	residents have the courtesy and respe	us treatment. Patien right to be treated wit ct for their individuali rsons providing servi	th ty by				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED	
		00112		B. WING _			C 9/2012	
NAME OF F	PROVIDER OR SUPPLIER	00112	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	10/1	3/2012	
			INTRY CLUI Valley, Mi					
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE		
21805	Continued From page 43			21805				
	by: Based on interview facility failed to ensiduring personal car reviewed in the san Findings include: R130 was re-admitt diagnoses that includisease and periph day Minimum Data 08/15/12, indicated and was cognitively indicated R130 requencouragement, su for personal hygien	and document reviewer privacy was proves for 1 of 3 resident apple for privacy. ted on 05/03/12, with uded stage IV chroniceral vascular disease Set (MDS) assessm R130 was alert and intact. In addition, it uired minimal assistate pervision and cues for and dressing need in physical assist for waste of the privacy of th	w, the ided ts (R130) c kidney e. The 30 ent, dated oriented t also ance of rom staff s. R130					
	regarding nursing s during morning care preferred to wash he bedside, to sustain would leave his roo who passed by to vexpressed his frust want others to see his multiple request the staff did not do On 10/17/12, at 2:1 Registered Nurse, I assistants (NAR) di room doors and newould conduct audi	0 p.m., R130 voiced taff not providing himes. R130 indicated the imself in the morning his independence arm door wide open foiew him naked. R13 rations and said no other naked and that its to have his room dit. 4 p.m. Unit Manager RN (B) verified that not always shut reseded reminders where the sof cares. RN(B) intended the reducation of the second street of the	n privacy hat he gs, at his nd staff r people 0 one would despite loor shut, f, sursing sidents' n RN (B) ndicated					

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		COMPLI	(X3) DATE SURVEY COMPLETED C	
		00112		B. WING _			9/2012	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
				INTRY CLUI VALLEY, MI				
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	(X5) COMPLETE DATE		
21805	importance of ensu SUGGESTED MET director of nursing of policies and proced are provided in rega of nursing or design appropriate staff me The director of nursi monitoring systems compliance	ring privacy during carring privacy during carring privacy during carring for designee could deflures to ensure residered and stopping and privacy. The enee could educate all embers policy and privacy or designee could	TION: The evelop ents rights director I rocedures. Id develop	21805				

6899