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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5OOY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LAKE RIDGE**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **01/31/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **175** (L18)

13.Total Certified Beds **175** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 01/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/21/2016
(L33)

Posted 02/03/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245105
January 31, 2017

Ms. Diane Willette, Administrator
Golden Livingcenter - Lake Ridge
2727 North Victoria
Roseville, MN 55113

Dear Ms. Willette:

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 January 22, 2017 the above facility is certified for or recommended for:

175 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 175 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245105 Y1	A. Building B. Wing Y2	1/31/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0253	Correction	ID Prefix F0272	Correction	ID Prefix F0279	Correction
Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	01/22/2017	LSC	01/22/2017	LSC	01/22/2017
ID Prefix F0309	Correction	ID Prefix F0314	Correction	ID Prefix F0431	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	01/22/2017	LSC	01/22/2017	LSC	01/22/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 01/31/2017	SIGNATURE OF SURVEYOR 16022	DATE 01/31/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/10/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5OOY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LAKE RIDGE**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **11/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **175** (L18)

13.Total Certified Beds 175 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sheryl Reed, HFE NE II — 12/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 12/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 12/21/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1524

November 28, 2016

Ms. Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, MN 55113

RE: Project Number S5105028 and Complaint Numbers H5105123, H5105127, H5105130, H5105131

Dear Ms. Willette:

On November 10, 2016, 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 November 10, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5105123, H5105127, H5105130, and H5105131 that were found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 215-9697

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 December 20, 2016, 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 February 10, 2017 (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 May 10, 2017 (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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification and licensing survey was conducted and complaint investigations were also completed at the time of the standard survey. An investigation of complaints H#5105123, H#5105127, H#5105130, H#5105131 were completed and found not to be substantiated.	F 000 12/8/16 SER	Submission of this response and plan of correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and it also is not to be construed as an admission of fault by the facility, the executive director or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction does not constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of the plan of correction within 10 days of the survey findings as a condition to participate in Title 18 and Title 19 programs. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not maintain a dining environment that was comfortable for resident (R114) and had the potential to affect residents who sat at the tables in the dining room that were close to the windows.	F 253		

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

Diane Willett | Executive Director | 12-6-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 Findings include: During a stage one interview on 11/8/16 at 10:09 a.m., a family member of R114 stated that the dining room on R114's dementia care unit had window curtains that did not close, the dining tables were very close to those windows, and the heat and direct sunlight was uncomfortable for R114 and for other residents at those tables. The family member also reported that R114 lived on a unit designated for advanced dementia care and many of the residents using that dining room were unable to advocate for themselves. The dining room of R114 was located in a dementia care unit, had open curtains on large windows, and the dining tables were close to the windows. The window curtains were permanently affixed into an open position. There was one document binder clip attached to the curtains where staff had tried to pull the curtains together and secure them, however, only a small part of the lower window was covered by this attempt and the upper sections of the window remained uncovered, allowing the sun to shine in on the tables while residents ate. The maintenance director and executive director were on the environmental tour, acknowledged these issues and stated that they would be fixed immediately. The executive director stated that new window coverings with sun protection would be explored for the dining rooms on R114's unit. The maintenance director stated that all rooms are audited quarterly and repairs are made as needed.	F 253	F253 Facility adhered curtain to wall so curtain can be closed during hours of sunlight and temperature changes 12-2-2016. Facility audited curtains throughout building for working order and will monitor for sunlight and/or temperature changes completed by environmental services 12/16/2016. Environmental services is responsible and will audit and evaluate curtains for functioning properly for season changes during daily cleaning of windows. Staff were re-educate on how to report concerns. Facility will evaluate for effectiveness and findings will be reported in monthly quality assurance. Completion date 12-19-2016	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 Resident R50 is no longer a resident in the facility. All other residents with wounds will be audited for timely documentation and assessments. Wound nurse and/or nurse manager and/or designee will audit all pressure ulcer assessment documentation currently in house to ensure consistency and timeliness of wound documentation. Re-education of nursing documentation will be provided for those who complete wound rounds and care. Thereafter all pressure ulcer assessments will be audited within 24 hours of the assessment (initial or weekly) to ensure consistency and timeliness of documentation by the wound nurse/and or nurse manager and/or designee are responsible for audits and assessments. con't	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not regularly and comprehensively assess pressure ulcers for 1 of 3 residents (R50) reviewed for pressure ulcers. Findings include: Record review revealed an Admission Record showing that R50 was admitted to the facility on 9/8/16 and discharged to another facility on 10/21/16. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/11/16, described a right ankle pressure ulcer that was identified on 9/8/16--3 centimeters (cm) x 1 cm, stage 3. The next assessment for this wound was dated 9/23/16, measured the wound as 1.75 cm x 2 cm, and did not include staging. Two more Wound Round Worksheets for this wound were done on 10/13/16 and 10/19/16 and included measurements of the wound, but no staging. The 10/19/16 Wound Round Worksheet showed that the wound had decreased in size to 1.5 cm x 1 cm. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/23/16, was also found in the record for buttock wounds identified on 9/19/16 that included measurements of these wounds, but no staging. No other comprehensive assessment of these wounds, including staging and measurement, was found. The plan of care for R50, last revised 9/29/16, contained a Focus for pressure ulcers, with an entry in the Interventions section that read, "Weekly Wound assessment."	F 272	Compliance of documentation will be reviewed and findings will be reported in monthly quality assurance. Completion date 12-19-2016 RECEIVED DEC 07 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4 When interviewed on 11/10/16 at 11:18 a.m., registered nurse (RN)-A stated that she could not locate any other comprehensive wound assessments for these wounds. She went on to explain that R50 did refuse assessment of his wounds at times and usually would only allow it during the night when he was in bed. The resident's care plan did not identify a problem of the resident refusing wound assessments or interventions to accommodate the resident's wound assessment preferences.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).		F279 Resident R114 lack of integration of hospice plan of care with the facility's plan of care. Plan of care has been revised and updated to reflect integration of goals and interventions. Facility nurse mangers/MDS Coordinators have reviewed and revised all other hospice care plans for a more detailed integration plan of care with hospice. Hospice providers have been educated and included in the process.	con't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive and individualized plan of care regarding hospice care for 1 of 1 resident (R114) reviewed for hospice. Findings include: Document review revealed a Hospice Certification and Plan of Treatment form showing that R114 was certified for hospice care through 11/15/16, related to vascular dementia. The facility's current care plan, dated 9/12/16, contained only one Focus related to hospice that read, "Patient is on Hospice care related to: End of Life Care." Several of the other Focus sections of the care plan contained interventions that read, "See also hospice CP," with no other details of goals or interventions. The record also contained an IDT Care Plan form from the hospice provider, updated 10/26/16, that was generic, with few specific details about R114. When interviewed on 11/10/16, at 11 a.m. registered nurse (RN)-B stated that facility staff used both care plans for the resident, and looked to the hospice provider's care plan for most of the hospice direction. She stated that she understood the need to individualize and coordinate the care plans, and would work on them.	F 279	Upon hospice admission or sign on, a care plan will be developed to integrate goals and interventions within 72 hours of agreement. Audits will be conducted by social services weekly for 1 month, bi-weekly for the next month and randomly thereafter, for review of completion of care plans, social services responsible. Audits will be reviewed and findings will be shared in monthly quality assurance. Completion date 12-19-2016	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive and individualized plan of care regarding hospice care for 1 of 1 resident (R114) reviewed for hospice. Findings include: Document review revealed a Hospice Certification and Plan of Treatment form showing that R114 was certified for hospice care through 11/15/16, related to vascular dementia. The facility's current care plan, dated 9/12/16, contained only one Focus related to hospice that read, "Patient is on Hospice care related to: End of Life Care." Several of the other Focus sections of the care plan contained interventions that read, "See also hospice CP," with no other details of goals or interventions. The record also contained an IDT Care Plan form from the hospice provider, updated 10/26/16, that was generic, with few specific details about R114. When interviewed on 11/10/16, at 11 a.m. registered nurse (RN)-B stated that facility staff used both care plans for the resident, and looked to the hospice provider's care plan for most of the hospice direction. She stated that she understood the need to individualize and coordinate the care plans, and would work on them.	F 309	F309 Resident R114 lack of integration of hospice plan of care and the facility's. Plan of care has been revised and updated to reflect detailed goals and interventions. Facility nurse mangers/MDS Coordinators have reviewed and revised all other hospice care plans for a more detailed integration plan of care with hospice. Hospice providers have been educated and included in the process. Upon hospice admission or sign on, a care plan will be developed to integrate goals and interventions within 72 hours of agreement. Audits will be conducted by social services weekly for 1 month, bi-weekly for the next month and randomly thereafter, for review of completion of care plans, social services responsible. con't	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7	F309	con't	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES		Audits will be reviewed and findings will be shared in monthly quality assurance.	
	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.		Completion date 12-19-2016	
	This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not provide the necessary care and services of regular and comprehensive assessment of pressure ulcers for 1 of 3 residents (R50) reviewed for pressure ulcers.			
	Findings include:			
	Record review revealed an Admission Record showing that R50 was admitted to the facility on 9/8/16 and discharged to another facility on 10/21/16. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/11/16, described a right ankle pressure ulcer that was identified on 9/8/16--3 centimeters (cm) x 1 cm, stage 3. The next assessment for this wound was dated 9/23/16, measured the wound as 1.75 cm x 2 cm, and did not include staging. Two more Wound Round Worksheets for this wound were done on 10/13/16 and 10/19/16 and included measurements of the wound, but no staging. The 10/19/16 Wound Round Worksheet showed that the wound had decreased in size to 1.5 cm x 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 cm. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/23/16, was also found in the record for buttock wounds identified on 9/19/16 that included measurements of these wounds, but no staging. No other comprehensive assessments of these wounds, including staging and measurement, was found. The plan of care for R50, last revised 9/29/16, contained a Focus for pressure ulcers, with an entry in the Interventions section that read, "Weekly Wound assessment." When interviewed on 11/10/16 at 11:18 a.m., registered nurse (RN)-A stated that she could not locate any other comprehensive wound assessments for these wounds. She went on to explain that R50 did refuse assessment of his wounds at times and usually would only allow it during the night when he was in bed. The resident's care plan did not identify a problem of the resident refusing wound assessment or interventions to accommodate the resident's wound assessment preferences.	F 314	F314 Resident R50 is no longer a resident in the facility. All other residents with wounds will be audited for timely documentation. Wound nurse and/or nurse manager and/or designee will audit all pressure ulcer assessment documentation currently in house to ensure consistency and timeliness of wound documentation. Re-education will be provided to nursing staff that complete wound rounds and care. Thereafter all pressure ulcer assessments will be audited within 24 hours of the assessment (initial or weekly) to ensure consistency and timeliness of documentation by the wound nurse/and or nurse manager and/or designee is responsible. Compliance of documentation will be reviewed and findings will be reported in monthly quality assurance. Completion date 12-19-2016	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 9 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 4 of 25 residents (R186, R166, R148 and R231) reviewed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R186, R166, R148 and R231, which included	F 431	F431 Facility medications that were not labeled with a date and those expired medications that were not taken out of storage were immediately corrected for all four residents affected. Nurse Managers audited all medication carts for labeling dates and expiration of medications. The Nurse Manager and /or designee will monitor for compliance Monday-Friday and the nursing supervisors and/or designee will complete on weekends: daily audits for 4 weeks, then 3 carts per week for 4 weeks and then randomly thereafter, director of nursing will be responsible for compliance. Medication cart audits will be reviewed and findings will be reported monthly in quality assurance. Completion date 12-19-2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 10 eye drops, insulin pens and insulin vials, lacked dates to indicate when they were opened and expired. During a medication storage tour on 11/8/16 at 3:25 p.m. with licensed practical nurse (LPN)-A, in subacute unit medication Cart 2, multiple opened, used and undated bottles and insulin pen were stored in the cart. Observations included the following: R186's Lumigan (for increase pressure in eyes) eye drop bottle was opened, used and was undated. R166's Lantus (for diabetes) insulin pen was opened, used and was undated. On 11/8/16, at 3:25 p.m. LPN-A verified the medications needed to be labeled and stored properly. LPN-A added that the eye drop bottle should be dated when opened. During a medication observation on 11/8/16 at 3:35 p.m. with LPN-B, the 500 wing medication Cart was reviewed. The following observation was made: R148's Dexamethasone suspension (for eye irritation) eye drop bottle was opened, used and undated. On 11/8/16, at 3:35 p.m. LPN-B confirmed medications should be labeled and stored properly. LPN-B explained that the expectation is that "it should be dated when opened". During the medication administration on 11/8/16, at 4:05 p.m., with LPN-C, Victoria medication cart was reviewed. The following observation was made:	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 11 R231's NPH [Human] [Isophane] (for diabetes) insulin vial was opened, used and dated 9/8/16. On 11/8/16, at 4:05 a.m. LPN-C verified medications should be labeled and stored properly. LPN-C acknowledged that the insulin vial dated 9/8/16 had been opened and used for 2 months and stated, "I am going to get a new insulin vial." On 11/9/16 at 7:29 a.m. the director of nursing stated, "My expectation is once an eye drop bottle is opened and used, it needs to be dated. Insulin vials have to be removed from the medication cart after 28 days of use. We will be providing re-education to staff regarding these issues." On 11/9/16 at 2:29 a.m. the clinical pharmacist explaind that after removing Insulin vials from the refrigerator they should only be used for 28 days Undated guideline form, MEDICATIONS TO DATE WHEN OPENED, directed, "insulin Refrig (refrigerator) til open, then room temp (temperature) 28 days after open". Policy and procedure titled STORAGE OF MEDICATIONS, dated 05/12, reads, "E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a 'date opened' sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a 'date opened' and 'expiration' notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating ... H. All expired medications will	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner."	F 431		

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

F5105028

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	**2727 NORTH VICTORIA ROSEVILLE, MN 55113**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 09,2016. At the time of this survey, Golden Livingcenter Lake Ridge was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Living Center Lake Ridge was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II (222) construction. The entire building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detectors at all smoke barrier doors that are held open and with detection in areas open to the corridor. The facility has 30-foot on center corridor smoke detection in the 1983 addition (Woodhill) that is on the fire alarm system. Hazardous areas have automatic fire detectors	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	**2727 NORTH VICTORIA ROSEVILLE, MN 55113**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 that are on the fire alarm system in accordance with the Minnesota State Fire Code. The building is divided into 9 smoke zones with 1/2 hour fire rated barriers. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 175 beds and had a census of 140 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 1524

November 28, 2016

Ms. Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, MN 55113

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5105028

Dear Ms. Willette:

The above facility was surveyed on November 7, 2016 through November 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5105123, H5105127, H5105130, and H5105131 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested

Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793 Fax: (651) 215-9697

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 Susanne Reuss at 651-201-3793.

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,

Kamala Fiske-Downing

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

Enclosure(s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 7 through November 10, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to:	2 000 12/8/16 SER	RECEIVED DEC 07 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION Please see correction orders for the standard survey. Completion date 12-19-2016	

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

Diane Willett | Executive Director | 12-6-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 7 through November 10, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Minnesota Department of Health Susanne Reuss, Unit Supervisor PO Box 64900 St. Paul, MN 55164-0900 An investigation of complaints H#5105123, H#5105127, H#5105130, H#5105131 were completed and found not to be substantiated.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential;	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 2 I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not regularly and comprehensively assess pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. Findings include: Record review revealed an Admission Record showing that R50 was admitted to the facility on 9/8/16 and discharged to another facility on 10/21/16. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/11/16, described a right ankle pressure ulcer that was identified on 9/8/16--3 centimeters (cm) x 1 cm, stage 3. The next assessment for this wound was dated 9/23/16, measured the wound as 1.75 cm x 2 cm, and did not include staging. Two more Wound Round Worksheets for this wound were done on 10/13/16 and 10/19/16 and included measurements of the wound, but no staging. The 10/19/16 Wound Round Worksheet showed that the wound had decreased in size to 1.5 cm x 1 cm. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/23/16, was also found in the record for buttock wounds identified on 9/19/16 that included measurements of these wounds, but no staging. No other comprehensive assessment of these wounds, including staging and measurement, was found.	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 3 The plan of care for R50, last revised 9/29/16, contained a Focus for pressure ulcers, with an entry in the Interventions section that read, "Weekly Wound assessment." When interviewed on 11/10/16 at 11:18 a.m., registered nurse (RN)-A stated that she could not locate any other comprehensive wound assessments for these wounds. She went on to explain that R50 did refuse assessment of his wounds at times and usually would only allow it during the night when he was in bed. The resident's care plan did not identify a problem of the resident refusing wound assessments or interventions to accommodate the resident's wound assessment preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to conducting assessments of pressure ulcers for are being developed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are completing on going assessments of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4 comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive and individualized plan of care regarding hospice care for 1 of 1 resident (R114) reviewed for hospice. Findings include: Document review revealed a Hospice Certification and Plan of Treatment form showing that R114 was certified for hospice care through 11/15/16, related to vascular dementia. The facility's current care plan, dated 9/12/16, contained only one Focus related to hospice that read, "Patient is on Hospice care related to: End of Life Care." Several of the other Focus sections of the care plan contained interventions that read, "See also hospice CP," with no other details of goals or interventions. The record also contained an IDT Care Plan form from the hospice provider, updated 10/26/16, that was generic, with few specific details about R114. When interviewed on 11/10/16, at 11 a.m. registered nurse (RN)-B stated that facility staff used both care plans for the resident, and looked to the hospice provider's care plan for most of the hospice direction. She stated that she understood the need to individualize and	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 5 coordinate the care plans, and would work on them. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual are being developed/ The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are developing a care plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive and individualized plan of care regarding hospice care	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 for 1 of 1 resident (R114) reviewed for hospice. Findings include: Document review revealed a Hospice Certification and Plan of Treatment form showing that R114 was certified for hospice care through 11/15/16, related to vascular dementia. The facility's current care plan, dated 9/12/16, contained only one Focus related to hospice that read, "Patient is on Hospice care related to: End of Life Care." Several of the other Focus sections of the care plan contained interventions that read, "See also hospice CP," with no other details of goals or interventions. The record also contained an IDT Care Plan form from the hospice provider, updated 10/26/16, that was generic, with few specific details about R114. When interviewed on 11/10/16, at 11 a.m. registered nurse (RN)-B stated that facility staff used both care plans for the resident, and looked to the hospice provider's care plan for most of the hospice direction. She stated that she understood the need to individualize and coordinate the care plans, and would work on them. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures related to development of plan of care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide the necessary care and services of regular and comprehensive assessment of pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. Findings include: Record review revealed an Admission Record showing that R50 was admitted to the facility on 9/8/16 and discharged to another facility on 10/21/16. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/11/16, described a right ankle pressure ulcer that was identified on 9/8/16--3 centimeters (cm) x 1 cm, stage 3. The next assessment for this wound was dated 9/23/16, measured the wound as 1.75 cm x 2 cm,	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 and did not include staging. Two more Wound Round Worksheets for this wound were done on 10/13/16 and 10/19/16 and included measurements of the wound, but no staging. The 10/19/16 Wound Round Worksheet showed that the wound had decreased in size to 1.5 cm x 1 cm. A Wound Evaluation Flow Sheet Multiple Weeks form, dated 9/23/16, was also found in the record for buttock wounds identified on 9/19/16 that included measurements of these wounds, but no staging. No other comprehensive assessments of these wounds, including staging and measurement, was found. The plan of care for R50, last revised 9/29/16, contained a Focus for pressure ulcers, with an entry in the Interventions section that read, "Weekly Wound assessment." When interviewed on 11/10/16 at 11:18 a.m., registered nurse (RN)-A stated that she could not locate any other comprehensive wound assessments for these wounds. She went on to explain that R50 did refuse assessment of his wounds at times and usually would only allow it during the night when he was in bed. The resident's care plan did not identify a problem of the resident refusing wound assessment or interventions to accommodate the resident's wound assessment preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
	314			
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by:	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 10 Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 4 of 25 residents (R186, R166, R148 and R231) reviewed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R186, R166, R148 and R231, which included eye drops, insulin pens and insulin vials, lacked dates to indicate when they were opened and expired. During a medication storage tour on 11/8/16 at 3:25 p.m. with licensed practical nurse (LPN)-A, in subacute unit medication Cart 2, multiple opened, used and undated bottles and insulin pen were stored in the cart. Observations included the following: R186's Lumigan (for increase pressure in eyes) eye drop bottle was opened, used and was undated. R166's Lantus (for diabetes) insulin pen was opened, used and was undated. On 11/8/16, at 3:25 p.m. LPN-A verified the medications needed to be labeled and stored properly. LPN-A added that the eye drop bottle should be dated when opened. During a medication observation on 11/8/16 at 3:35 p.m. with LPN-B, the 500 wing medication Cart was reviewed. The following observation was made: R148's Dexamethasone suspension (for eye irritation) eye drop bottle was opened, used and	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 11 undated. On 11/8/16, at 3:35 p.m. LPN-B confirmed medications should be labeled and stored properly. LPN-B explained that the expectation is that "it should be dated when opened". During the medication administration on 11/8/16, at 4:05 p.m., with LPN-C, Victoria medication cart was reviewed. The following observation was made: R231's NPH [Human] [Isophane] (for diabetes) insulin vial was opened, used and dated 9/8/16. On 11/8/16, at 4:05 a.m. LPN-C verified medications should be labeled and stored properly. LPN-C acknowledged that the insulin vial dated 9/8/16 had been opened and used for 2 months and stated, "I am going to get a new insulin vial." On 11/9/16 at 7:29 a.m. the director of nursing stated, "My expectation is once an eye drop bottle is opened and used, it needs to be dated. Insulin vials have to be removed from the medication cart after 28 days of use. We will be providing re-education to staff regarding these issues." On 11/9/16 at 2:29 a.m. the clinical pharmacist explaind that after removing Insulin vials from the refrigerator they should only be used for 28 days Undated guideline form, MEDICATIONS TO DATE WHEN OPENED, directed, "insulin Refrig (refrigerator) til open, then room temp (temperature) 28 days after open". Policy and procedure titled STORAGE OF MEDICATIONS, dated 05/12, reads, "E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 12 dated. 1. The nurse shall place a 'date opened' sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a 'date opened' and 'expiration' notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating ... H. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 13 routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility did not maintain a dining environment that was comfortable for resident (R114) and had the potential to affect residents who sat at the tables in the dining room that were close to the windows. Findings include: During a stage one interview on 11/8/16 at 10:09 a.m., a family member of R114 stated that the dining room on R114's dementia care unit had window curtains that did not close, the dining tables were very close to those windows, and the heat and direct sunlight was uncomfortable for R114 and for other residents at those tables. The family member also reported that R114 lived on a unit designated for advanced dementia care and many of the residents using that dining room were unable to advocate for themselves. The dining room of R114 was located in a dementia care unit, had open curtains on large windows, and the dining tables were close to the windows. The window curtains were permanently affixed into an open position. There was one document binder clip attached to the curtains where staff had tried to pull the curtains together and secure them, however, only a small part of the lower window was covered by this attempt and the upper sections of the window remained uncovered, allowing the sun to shine in on the tables while residents ate. The maintenance director and executive director were on the environmental tour, acknowledged	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 14 these issues and stated that they would be fixed immediately. The executive director stated that new window coverings with sun protection would be explored for the dining rooms on R114's unit. The maintenance director stated that all rooms are audited quarterly and repairs are made as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION; Twenty -one (21) days	21685		