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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5QZK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2.STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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 **09/07/2016** (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 **72** (L18)

13.Total Certified Beds **72** (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
	72			
(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 :
Sue Reuss, Unit Supervisor — 09/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/16/2016 (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
12/01/1986
(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) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 09/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245394
September 16, 2016

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Dear Mr. Carlson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 30, 2016 the above facility is certified for or recommended for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 16, 2016

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: Project Numbers S5394027, H5394057, H5394056

Dear Mr. Carlson:

On August 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 21, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 21, 2016, effective August 30, 2016 and therefore remedies outlined in our letter to you dated August 5, 2016, will not be imposed.

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

Feel free to contact me if you have 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

Enclosure

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
245394 Y1	A. Building B. Wing Y2	9/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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 F0247	Correction	ID Prefix F0253	Correction	ID Prefix F0279	Correction
Reg. # 483.15(e)(2)	Completed	Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	08/30/2016	LSC	08/30/2016	LSC	08/30/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	08/30/2016	LSC	08/30/2016	LSC	08/30/2016
ID Prefix F0441	Correction	ID Prefix F0463	Correction	ID Prefix F0465	Correction
Reg. # 483.65	Completed	Reg. # 483.70(f)	Completed	Reg. # 483.70(h)	Completed
LSC	08/30/2016	LSC	08/30/2016	LSC	08/30/2016
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 09/16/2016	SIGNATURE OF SURVEYOR 16022	DATE 09/07/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245394	A. Building 01 - MAIN BUILDING 01 B. Wing	9/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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 Reg. # NFPA 101 LSC K0025	Correction Completed 08/30/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 08/30/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	09/16/2016	37009	09/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5QZK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2.STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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 **07/21/2016** (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 **72** (L18)
13.Total Certified Beds **72** (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
	72			
(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 :
Mary Heim, HPR - Social Work 08/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 08/22/2016 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 08/23/2016 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

Electronically delivered
August 5, 2016

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: Project Number S5394027 & H5394056 & H5394057

Dear Mr. Carlson:

On July 21, 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. In addition, at the time of the July 21, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5394056, which was substantiated.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 21, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5394057 that was 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;

Electronic 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
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
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 August 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 30, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 October 21, 2016 (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 January 21, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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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 survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaints H5394057 and H5394056 were completed. The H5394056 complaint was substantiated and deficiencies were cited at F282 and F312. The H5394057 complaint was not substantiated.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents reviewed with changes in room or roommate were given notice, R59 and R44. Findings include:	F 247	Resident #44 and #59 has documented interview of room change, follow up and resolution. Residents have the potential to be affected if not given timely notice of	8/30/16

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

Electronically Signed | 08/15/2016

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F 247	Continued From page 1 On 7/19/16 at 1:52 p.m. R59 reported a new roommate moved in with him recently and he was not given prior notice. R59 reported he found out there was a new roommate when his new roommate showed up. R59 reported he felt a little upset. R59 added no one had checked to see if the new roommate situation was working out. On 7/21/16 at 8:29 a.m., the social service director (SSD) reported the facility needed to make room and roommate changes very quickly due to a situation involving resident conflict, unrelated to R59. R59 reported he did not want to move rooms, but a new roommate moved into the room he was living in. SSD reported she thought R59 was aware he was getting a new roommate. SSD could find no documentation regarding R59 being given notice about a new roommate or what his response was to getting a new roommate. SSD reported she had residents sign a room change notice if they were being moved to a new room, but did not have a process for giving notice to residents getting a new roommate. Review of census list documentation for R59 and R33 revealed R33 moved into the room with R59 on 7/15/16. Review of R59's progress notes from July 1st 2016 to July 21st 2016 revealed R59 was not given notice prior to roommate change. On 7/18/16 at 2:06 p.m., R44 reported a new roommate moved in and he was not given notice prior to getting a new roommate. On 7/21/17 at 8:43 a.m., SSD reported there was no documentation that R44 was given notice of a new roommate.	F 247	room/roommate change Documented education of staff on the living center room change process. Monthly Audits of room changes to ensure notice before room/roommate changes-follow up and resolution ED/designee is responsible for compliance Results of these audits will be reviewed at the facility QA meeting for further recommendation.	

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F 247	Continued From page 2 Review of census list documentation for R44 and R72 revealed R72 moved into the room with R44 on 12/22/15. Review of 44's progress notes for December 2015 revealed no documentation R44 was notified of R72 moving in with him. Review of the Notice of Room Relocation, undated, revealed a process for notifying residents of room changes, but no process for roommate changes.	F 247		
F 253 SS=D	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, interview and document review, the facility failed to ensure resident rooms were maintained in a manner that was comfortable and functional for 3 of 35 residents reviewed, R72, R13 and R54. Findings include: On 7/18/16 at 1:46 p.m., R72 voiced a concern about the toilet in his shared bathroom had been leaking for several months and the bathroom had an odor of "sewage." A rust colored ring was noted around the toilet and the bathroom had an odor of stale urine. During the environmental tour on 7/21/16, at 10:20 a.m. the floor surrounding the toilet was wet. The director of maintenance was on the tour and stated that he had tried fixing	F 253	R72 toilet has been replaced and repaired. R13 bottom left and right corners of closet have been repaired. R54 room has been deep cleaned and floor has been stripped and waxed. Resident rooms have been inspected and repairs completed as necessary. All residents have the potential to be effected if not provided a sanitary, orderly, and comfortable interior. Staff to be educated on system to identify issues as needing repair. Random weekly audits of 2 rooms per week to ensure any repairs have been	8/30/16

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F 253	Continued From page 3 the toilet leak himself previously, but the repair did not work. He went on to explain that he planned to get an outside vendor to fix the toilet leak, but he did not have a work order or appointment in place for this repair. On 07/18/2016 at 1:36 p.m., R13 stated that the wood and plastic veneer on her closet doors was curling up bottom corners and her clothing had gotten caught in the protrusions recently. During the environmental tour the left and right bottom corners of R13's closet were curled up and protruding. The director of housekeeping was on the tour and stated that he had been unaware of this closet needing repair, but would take care of it immediately. On 07/19/2016 at 02:16 p.m. surveyor noted odor in R54's room. R54 is in a private room an unable to respond to questions. During the environmental tour a strong urine odor permeated the room of R54. R54's clothing and bedding appeared clean and dry. The administrator was on the tour and stated that the resident has confusion and urinated on the floor and heating registers. The administrator also explained that these areas are immediately cleaned and a commode has been placed next to the resident's bed to encourage him to use that for toileting instead of other areas of the room. No wet spots or stains were visible in the room. The director of housekeeping was on the tour and stated that this room was deep cleaned daily and he would schedule a wax stripping some time in the next two weeks. On 7/21/19 at 2:29 p.m. the director of housekeeping stated that he was immediately placing a new mattress on the bed of R54.	F 253	completed. Quarterly room checks to inspect beds and other furnishings for proper operation and repair as needed. ED/designee is responsible Results of these audits will be reviewed at the facility QA meeting for further recommendation.	

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F 253	Continued From page 4 When interviewed on the environmental tour, the director of maintenance and the director of housekeeping stated that they hoped that housekeeping staff would notice issues in residents' rooms that need repair when they are doing daily cleaning and then report those issues so a work order could be done and the repair completed. During the environmental tour, the administrator was asked how often rooms are audited. He stated that all rooms are thoroughly inspected quarterly and that had last been done in June 2016.	F 253		
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).	F 279		8/30/16

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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 coordinated and individualized plan of care regarding hospice for 1 of 1 resident (R28) reviewed for hospice care. Findings include: Record review revealed an Admission Record with an admission date of 4/20/11 for R28. The record also contained a Hospice Certification and Plan of Treatment form showing that R28 began hospice care on 09/01/2015. This form listed the primary hospice diagnosis as senile degeneration of the brain. The facility's current plan of care, dated 06/03/16, contained only two focus entries for hospice care. One focus read, "Potential for nutrition risk due to h/o wt loss, mech altered diet. Hospice focus care, ' and the other read simply, "Patient is on Hospice care related to: End of life care." The record contained a plan of care from the hospice provider, dated 09/01/15, that was generic and did not include individualized details specific to the resident. When interviewed on 07/21/16, at 2:16 p.m. registered nurse (RN)-A ,the nurse manager for this unit, stated that facility staff generally follow the facility's care plan and he would need to sit down with the hospice nurse to be able to coordinate the facility's care plan with the hospice provider's care plan. He went on to say that he would try to do that and better integrate the care plans.	F 279	Resident R28 care plan updated to include individualized details specific to the resident as related to hospice. All residents receiving hospice services have the potential to be effected if care plans are not updated to reflect current needs. Education to staff to update care plans that will integrate hospice care plans and current interventions, review system of updating care plans during admission and as needed. DNS/designee is to complete random weekly audits of care plan and interventions to ensure that proper updates include resident specific individualized details related to hospice. Results of these audits will be reviewed at the facility QA meeting for further recommendation. DNS/designee is responsible for compliance	

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F 282	Continued From page 6	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to follow and update the care plan for 1 of 3 residents (R54) reviewed for activities of daily living and failed to follow the care plan for 1 of 3 (R54) reviewed for incontinence. Findings include: During random observations on 7/18,16, 7/19/16, and 7/20/16, R54 remained unshaven and had long thick gray whiskers on his cheeks, chin, upper and lower lip and under throat. R54's current comprehensive care plan indicated a self care impairment due to dementia and staff were to provide extensive assist of 2 with most activities of daily living. The care plan directed staff to provide personal hygiene with assist of one and to supervise, and assist as needed with shaving. The nursing assistant worksheet used to direct care indicated R54 needed to be assisted of 2 staff persons for all personal hygiene including grooming. On 7/18/16 at 10:16 a.m. R54 was in his room resting on the bed. Staff nurse was in room applying a band aid to an open area on right	F 282	Resident R54 care plan reviewed and revised as indicated regarding specific toileting cares and ADL cares. All residents have the potential to be effected if care plans are not updated to reflect current needs specific to toileting and activities of daily living. Education to staff to update care plans to include resident□s specific ADL plans, and toileting cares, review system of updating care plans during admission and as needed. DNS/designee is to complete random weekly audits of care plan and interventions to ensure that proper updates include activities of daily living and toileting specific cares. Results of these audits will be reviewed at the facility QA meeting for further recommendation. DNS/designee is responsible for compliance	8/30/16

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F 282	Continued From page 7	F 282		

elbow. R54's face had short gray whiskers on checks, chin, upper and lower lips and throat/upper neck area.

On 7/19/16 at 12:50 p.m., R54 was observed to have long whiskers on both facial checks, chin, upper and lower lip and on throat.

On 7/20/16 at 7:45 a.m., R54 was observed to have long thick facial hairs on both checks, chin and upper and lower lip and on neck. On 7/20/16 at 12:08 p.m., R54 ambulated down the hall to the 2nd floor dining room and sat at the first table waiting for lunch. R54's face still had thick and long facial hairs.

On 7/20/16 at 2:29 p.m., nursing assistant (NA)-A reported she had cared for R54 during the day. NA-A indicated she and another nursing assistant had gotten R54 dressed in the morning and verified R54 was not shaved in the morning or during the day. When asked about the facial grooming, NA-A indicated that it was too dangerous to shave him, that it would be dangerous to both her and the resident and she would not attempt to shave R54. This was due to R54's behaviors of hitting out. NA-A added being new to the job and just won't feel safe attempting to shave R54.

On 7/21/16 at 10:15 a.m. the clinical nurse manager (RN)-A indicated R54 had a recent significant change. RN-A indicated R54 has behaviors and can be difficult to provide cares for and that is why staff assistance of two is necessary. RN-A verified staff should be attempting to provide cares and updating license staff when assistance needed and verified the care plan was not being followed.

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F 282	Continued From page 8	F 282		

R54's care plan was not followed for incontinence care.

R54's care plan last revised on 6/03/16 indicated R54 was frequently incontinent of bladder and to check and change resident when resident allows. The nursing assistant worksheet indicated R54 was on a check and change program.

On 7/20/16 at 7:45 a.m., R54 was observed sitting in his room after being transferred to the lounge chair by nursing assistant (NA)-A. R54 stayed in his room until 12:08 p.m. At that time, R54 ambulated down the hall to the 2nd floor dining room and sat at the first table waiting for lunch. At 12:55 p.m. R54 remained at the same table eating lunch. R54 fed himself very slowly and as others completed their meal, they left the dining room At 2:09, the dining room had been cleaned and no additional residents were in the dining room. R54 remained in the dining room at the same table where he ate lunch. R54 talked to self and any staff persons who walked by. At 2:17 p.m. R54 stood up with use of walker and walked into 2nd dining room, looked around and returned to sit at the same table. At 2:33 p.m. NA-A pulled up the gripper sock of R54's foot so that it was properly covering the foot. At 2:36 p.m. NA-A verified what cares had been done for R54 and added she was going to work on another floor for the next shift. R54 remained in the dining room until 3:00 p.m.

On 7/20/16 at 2:30 p.m. the NA-A verified that she had gotten R54 up and dressed this am. R54 was dependent on staff for dressing and grooming and was incontinent of bladder. NA-A verified R54 would sometimes use the bedside

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F 282	Continued From page 9 commode and sometimes he will go to the bathroom to wash his hands. NA-A indicated R54 was having a good day. When asked about toileting NA-A added she was able to provide incontinent care for R54 that morning with the help of another nursing assistant but verified she had not tried to check or change him since the morning. On 7/21/16 at 10:15 a.m. the clinical nurse manager (RN)-A confirmed the care plan should be more patient specific when toileting cares should be provided. RN-A explained that a check and change program was to be toileted before and after meals and before hours of sleep. The RN-A indicated the nursing assistant should have attempted to check and change R54 on a more regular basis than one time a shift. RN-A indicated there was some confusion with verbage of the care plan and the nursing assistant worksheet.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a coordinated and individualized plan of care regarding hospice for 1	F 309	Resident R28 care plan updated to include individualized details specific to the resident as related to hospice while	8/30/16

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F 309	Continued From page 10 of 1 resident (R28) reviewed for hospice care. Findings include: Record review revealed an Admission Record with an admission date of 4/20/11 for R28. The record also contained a Hospice Certification and Plan of Treatment form showing that R28 began hospice care on 09/01/2015. This form listed the primary hospice diagnosis as senile degeneration of the brain. The facility's current plan of care, dated 06/03/16, contained only two focus entries for hospice care. One focus read, "Potential for nutrition risk due to h/o wt loss, mech altered diet. Hospice focus care, ' and the other read simply, "Patient is on Hospice care related to: End of life care." The record contained a plan of care from the hospice provider, dated 09/01/15, that was generic and did not include individualized details specific to the resident. When interviewed on 07/21/16, at 2:16 p.m. registered nurse (RN)-A ,the nurse manager for this unit, stated that facility staff generally follow the facility's care plan and he would need to sit down with the hospice nurse to be able to coordinate the facility's care plan with the hospice provider's care plan. He went on to say that he would try to do that and better integrate the care plans.	F 309	obtaining optimal improvement based on comprehensive resident assessment. All residents have the potential to be effected if care plans are not updated to reflect current needs. Education to staff to update care plans that will integrate hospice care plans and current interventions, review system of updating care plans during admission and as needed. DNS/designee is to complete random weekly audits of care plan and interventions to ensure that proper updates include resident specific individualized details related to hospice and resident assessment. Results of these audits will be reviewed at the facility QA meeting for further recommendation. DNS/designee is responsible for compliance	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		8/30/16

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F 312	Continued From page 11 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure a resident received personal grooming assistance for shaving for 1 of 3 residents (R54) reviewed for activities of daily living and failed to ensure a resident received incontinence care for 1 of 3 residents (R54) reviewed for incontinence. Findings include: During random observations on 7/18,16, 7/19/16, and 7/20/16, R54 remained unshaven and had long thick gray whiskers on his cheeks, chin upper and lower lip and under throat. R54's Significant Change Minimum Data Set, (MDS) dated 5/19/16, indicated the resident had impaired cognition skills and required extensive assistance of two staff persons with personal hygiene. The MDS indicated R54 displayed behaviors that included verbal, physical and other behaviors such as pacing, scratching, and pacing. R54 ' s current comprehensive care plan indicated a self care impairment due to dementia and staff were to provide extensive assist of 2 with most activities of daily living. The care plan directed staff to provide personal hygiene with assist of one and to supervise, and assist as needed with shaving. The nursing assistant worksheet used to direct care indicated R54 needed to be assisted of 2 staff persons for all	F 312	Resident R54 individualized care sheets reviewed and revised indicating resident specific toileting cares and ADL cares as related to MDS significant change. All residents have the potential to be effected if care plans are not updated to reflect current needs specific to toileting and activities of daily living. Education to staff to update care plans to include resident□s specific ADL plans, and toileting cares, review system of updating care plans during admission and as needed. DNS/designee is to complete random weekly audits of care plan and interventions to ensure that proper updates include activities of daily living and toileting specific cares as related to significant change to resident MDS. Results of these audits will be reviewed at the facility QA meeting for further recommendation. DNS/designee is responsible for compliance	

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	245394	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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personal hygiene including grooming.

On 7/18/16 at 10:16 a.m. R54 was in his room resting on the bed. Staff nurse was in room applying a band aid to an open area on right elbow. R54 face had short gray whiskers on checks, chin, upper and lower lips and throat/upper neck area.

On 7/19/16 at 12:50 p.m., R54 was observed to have long whiskers on both facial checks, chin, upper and lower lip and on throat.

On 7/20/16 at 7:45 a.m. R 54 was being transferred from sitting on his bed to the lounge chair in his room. R54 used a walker and was assisted by a nursing assistant. He was dressed in a dark tee shirt and dark slacks. R54 was observed to have long thick facial hairs on both checks, chin and upper and lower lip and on throat. On 7/20/16 at 12:08 p.m., R54 ambulated down to the hall to the 2nd floor dining room and sat at the first table waiting for lunch. R54 ' s face still had thick and long facial hairs.

On 7/20/16 at 2:29 p.m., nursing assistant (NA)-A reported she had cared for R54 during the day. NA-A indicated she and another nursing assistant had gotten R54 dressed in the morning and verified R54 was not shaved in the morning or during the day. When asked about the facial grooming, NA-A indicated that it was too dangerous to shave him, that it would be dangerous to both her and the resident and she would not attempt to shave R54. NA-A added being new to the job and just won ' t feel safe attempting to shave R54.

On 7/21/16 at 10:15 a.m. the clinical nurse

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manager (RN)-A indicated R5 4 had a recent significant change. RN-A indicated R54 has behaviors and can be difficult to provide cares for and that is why staff assistance of two is necessary. RN-A verified staff should be attempting to provide cares and updating license staff when assistance needed and verified the care plan was not being followed.

R54 did not receive incontinence care directed by the current care plan.

R54's Significant Change Minimum Data Set, (MDS) dated 5/19/16, indicated the resident had impaired cognition skills and required extensive assistance of two staff persons with personal hygiene and incontinence care. The MDS indicated R54 displayed behaviors that included verbal, physical and other behaviors such as pacing, scratching, and screaming.

R54's care plan last revised on 6/03/16 indicated R54 was frequently incontinent of bladder and to check and change resident when resident allows. The current nursing assistant worksheet indicated R54 was on a check and change program.

On 7/20/16 at 7:45 a.m., R54 was observed sitting in his room after being transferred to the lounge chair by nursing assistant (NA)-A. R54 stayed in his room until 12:08 p.m. At that time, R54 ambulated down the hall to the 2nd floor dining room and sat at the first table waiting for lunch. At 12:55 p.m. R54 remained at the same table eating lunch. R54 fed himself very slowly and as others completed their meal, they left the dining room At 2:09, the dining room had been cleaned and no additional residents were in the

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dining room. R54 remained in the dining room at the same table where he ate lunch. R54 talked to self and any staff person that walked by. At 2:17 p.m. R54 stood up with use of walker and walked into the 2nd dining room, looked around and returned to sit at the same table. At 2:33 p.m. NA-A pulled up the gripper sock of R54's foot so that it was properly covering the foot. At 2:36 p.m. NA-A verified what cares had been done for R54 and added she was going to work on another floor for the next shift. R54 remained in the dining room until 3:00 p.m.

On 7/20/16 at 2:30 p.m. the NA-A verified that she had gotten R54 up and dressed this am. R54 was dependent on staff for dressing and grooming and was incontinent of bladder. NA-A verified R54 would sometimes use the bedside commode and sometimes he will go to the bathroom to wash his hands. NA-A indicated R54 was having a good day. When asked about toileting NA-A added she was able to provide incontinent care for R54 that morning with the help of another nursing assistant but verified she had not tried to check or change him since the morning.

On 7/21/16 at 10:15 a.m. the clinical nurse manager (RN)-A confirmed the care plan should be more patient specific when toileting cares should be provided. RN-A explained that a check and change program was to be toileted before and after meals and before hours of sleep. RN-A indicated the nursing assistant should have attempted to check and change R54 on a more regular basis than one time a shift. RN-A indicated there was some confusion with verbiage of the care plan and the nursing assistant worksheet.

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F 312	Continued From page 15	F 312		
F 441 SS=F	, 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		8/30/16

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F 441	Continued From page 16 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the infection control program included ongoing trending and analysis of resident infections to prevent the spread of infections. This deficient practice had the potential to affect all 70 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from January 2016 through July 2016. The logs identified tracking records of residents with infections, symptoms cultures and treatment. However, the facility lacked documentation of analysis and or investigation of patterns identified. The facility utilized a form titled Line Listing of Resident Infections. The forms were filled out and identified by each month and separated by unit. Infections that have been noted in the facility in the past 6 months included urinary tract infections, pneumonia, and cellulitis. The forms were completed by the director of nursing (DON) after information was provided monthly by the unit clinical managers. The forms lacked any	F 441	Facility□s infection control logs have been implemented, updated, and corrected to include record tracking information of trending and analysis of residents with infection, their symptom□s cultures and treatments to identify and track patterns. All residents with infections, immobile, invasive devices, altered mental status, and compromised immune systems have the potential to be affected. Education provided to DNS of proper tracking and trending of analysis and investigative techniques to use in the facility. Infection control surveillance and trending documents implemented for facility. DNS/designee is responsible for compliance.	

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F 441	Continued From page 17 documentation of analysis and or investigation of patterns identified. For example, the form for the month of January 2016, indicated 4 of 8 infections were urinary tract infections. There was no documentation of any trending or analysis of these infections. The form did not identify if residents had symptoms of infections or if they were treated with antibiotics. On 7/21/16 at 11:55 a.m. the DON indicated she was responsible for the infection control program for the facility. The DON provided the lists of infections by unit for the months of January 2016 through July 2016. The DON reported that each infection is mentioned at the facility morning stand up meetings and any trends would be identified at the meeting. However, the DON verified there was no documentation of any discussion. The DON reported the infection control logs are taken to the quality assurance meetings. On 7/21/16 at 12:55 p.m. the DON verified the facility was not trending/analyzing all resident infections. The facility's policy and practices for Infection Control, last reviewed 11/23/15, identified an objective as bullet 1c. Review, establish and monitor environmental infection control approaches in accordance with CDC/HICPAC/OSHA guidelines and local or state requirements. 1h. Develop policies and procedure for the surveillance and monitoring of infection control practices. The Infection Control Committee policy last reviewed 11/23/16, indicated the committee meetings will cover at least: a. Directives from the health department (state and local) b. Surveillance reports of infections or infectious diseases, c. Policy review and revisions, d. Current infection control/prevention concerns; f. changes in	F 441	Surveillance, trending information, and infection control rates will be reviewed at the facility QA meeting for further recommendation.	

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F 441	Continued From page 18 regulations, guidelines and recommendations relative to infection control issues in healthcare facilities; h. Infection-related employee health issues; i. antibiotic utilization patterns and emergence of antibiotic-resistant organisms.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure resident call lights were functioning for 9 of 35 residents (R24, R4, R39, R49, R75, R56, R41, R64 and R74) reviewed for functioning call lights. Findings include: On 7/18/16, at 2:15 p.m. R24's bathroom was shared with R4 and R39. The emergency call light was observed to not be working. Nursing Assistant, (NA)-A confirmed it was not working and stated it was on the maintenance list for repair. On 7/19/16, at 12:50 p.m. RN-A confirmed the call light was not working and would call maintenance to fix it. On 7/19/16, at 12:40 p.m. R49's bathroom was shared with R75 and R56's bathroom was shared with R41. The emergency call light was observed to not be working. Licensed practical nurse (LPN)-A confirmed R49's and R56's bathroom	F 463	R24, R4, R39, R49, R75, R56, R41, R64 and R74 call lights have been repaired and functioning properly. All Resident room call lights have been inspected and repairs completed as necessary. All residents have the potential to be effected if not provided a communication system from nurse□s stations to resident rooms; and toilet and bathing facilities. Staff to be educated on system to identify call lights as needing repair. Random weekly audits of 2 rooms per week to ensure resident call lights are functioning properly. Quarterly room checks to inspect call lights and other furnishings for proper operation and repair as needed. ED/designee is responsible for	8/30/16

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F 463	Continued From page 19 call light did not work when turned on and stated the ceiling hallway call light outside the room should light up and at the nurse's station. LPN-A stated that when the bathroom light was turned off the emergency call light lit up in the hallway, which wasn't working correctly. On 7/19/16, at 12:48 p.m. registered nurse (RN)-A confirmed the call light was not working, indicated the light bulb could be out, and would inform maintenance. R64, when interviewed on 7/19/16 at 12:55 p.m. stated maintenance was notified the bathroom call light was not working about one month ago. R64 explained being told it would be fixed but stated the call light was not fixed and was still not functioning at this time. The bathroom emergency call light was turned on and did not activate the light in the hallway, but activated an alarm and red light at the nurses station. R64 expressed concern that if help was needed staff may not respond in a timely manner. During an interview on 7/19/16, at 1:13 p.m. licensed practical nurse (LPN)-B stated the call lights for R64 and R74's bathroom were not functioning and LPN-B would report it to the supervisor immediately. On 7/21/16 at 10:20 a.m., when interviewed during the environmental tour, the administrator was asked how often residents' call lights are audited for proper function. He stated that all rooms are thoroughly inspected quarterly and that had last been done in June 2016. The facility call light policy dated 1/26/2015, directed "procedure purpose: to assure call	F 463	compliance. Results of these audits/inspections will be reviewed at the facility QA meeting for further recommendation.	

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F 463	Continued From page 20 system is in proper working order... equipment: emergency call light in functioning order... procedure details: 4. For emergency call lights in bathrooms and shower and tub rooms, a light and a continuous sound will appear over the door of the room and on the board at the nursing station"...	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 28 rooms reviewed, rooms 120 and 214, were in good condition. This had the potential to impact 2 of 35 residents reviewed for environment. Findings include: On 07/18/16 at 1:34 p.m., during stage one observations, room 120 had a room air conditioner in the exterior wall with unpainted spackling surrounding the air conditioning unit and the baseboard near the bathroom door was loose and protruding. When observed again on the environmental tour on 7/21/16 at 10:20 a.m., the unpainted spackling remained. The director of maintenance was on the tour and stated that the baseboard would be fixed that day. On 07/19/16 at 12:52 p.m., during stage one	F 465	Room 120 unpainted spackling around AC unit has been painted and repaired. Baseboard near the bathroom door has been replaced and attached to wall. Room 214 bathroom door has gouge repaired and is closing properly. Resident rooms have been inspected and repairs completed as necessary. Residents, staff and the public have the potential to be effected if not provided a safe, functional, sanitary and comfortable environment. Staff to be educated on system to identify issues as needing repair. Random weekly audits of 2 rooms and/or common areas per week to ensure any repairs have been completed. Quarterly	8/30/16

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F 465	Continued From page 21 observations, the bathroom door in room 214 was sticking and difficult to open; also wood was gouged out in a large area around the door knob to the bathroom. The nurse manager, (RN)-A, of the unit was notified and was unaware of the issues. During the environmental tour the bathroom door was working easily, but the gouge in the wood around the door knob remained, with rough and splintered wood exposed. The director of maintenance was on the tour and stated that the door had been shaved and he would put a plate over the gouged area near the door knob. On 7/21/16 at 10:20 a.m., when interviewed on the environmental tour, the director of maintenance and the director of housekeeping stated that they hoped that housekeeping staff would notice issues in residents' rooms that need repair when they are doing daily cleaning and then report those issues so a work order could be done and the repair completed. During the environmental tour, the administrator was asked how often rooms are audited. He stated that all rooms are thoroughly inspected quarterly and that had last been done in June 2016.	F 465	room checks to inspect rooms and other furnishings for proper operation and repair as needed. ED/designee is responsible Results of these audits/inspections will be reviewed at the facility QA meeting for further recommendation.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 21, 2015. At the time of this survey, Golden Living Center Lynnhurst was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2016

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

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K 000	Continued From page 1	K 000		

Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Golden Living Center Lynnhurst is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1967, an addition was constructed to the northeast and was determined to be of Type II(222) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is automatic sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 69 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	**471 LYNNHURST AVENUE WEST** **SAINT PAUL, MN 55104**

(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 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect on 69 residents. Findings include: 1. On a facility tour between the hours of 09:30 AM and 01:30 PM on July 21, 2016, observation revealed that there were penetrations in the smoke barrier walls on the 1st and 2nd floors, above the smoke barrier doors. This deficient practice was verified by the Administrator at the time of the inspection.	K 025	All deficient areas noted by the state fire marshal during annual inspection will be repaired and/or constructed so they meet current life safety code requirement. We are working with a contractor and an architect to verify proper code requirements are met. ED/designee is responsible	8/30/16
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 69 residents.	K 144	Monthly schedule created with generator inspections weekly and under load for 30 minutes monthly Quarterly audit of generator logs	8/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	**471 LYNNHURST AVENUE WEST** **SAINT PAUL, MN 55104**

(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 144	Continued From page 3 Findings include: 1. On a facility tour between the hours of 09:30 AM and 01:30 PM on July 21, 2016, observation revealed that a monthly generator load test hasn't been documented since February 08, 2016. 2. On a facility tour between the hours of 09:30 AM and 01:30 PM on July 21, 2016, observation revealed that the facility is missing documentation for several weekly generator inspections between January 2016 and July 2016. These deficient practices were verified by the Administrator at the time of the inspection.	K 144	ED/designee is responsible	