DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5RL3 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00799 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) GOLDEN LIVINGCENTER - HENNING (L1)245540 1. Initial 2. Recertification (L4) 907 MARSHALL AVENUE, PO BOX 57 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56551 438670100 (L2)(L5) HENNING, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 04/01/2006 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 03/31/2016 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): ____ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 42 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 13. Total Certified Beds 42 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 42 (L37) (L38) (L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date Mark Meath Beth Nowling, HFE NEII 04/05/2016 **Enforcement Specialist** 05/05/2016 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: X 1. Facility is Eligible to Participate 3. Both of the Above : Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 04/01/1990 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change (L44) 00-Active (L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00454 (L28) (L31)

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

03/30/2016

(L32)

31. RO RECEIPT OF CMS-1539



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245540

May 5, 2016

Ms. Joan Gedde, Administrator Golden LivingCenter - Henning 907 Marshall Avenue, PO Box 57 Henning, Minnesota 56551

Dear Ms. Gedde:

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 March 21, 2016 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

Ms. Joan Gedde, Administrator Golden LivingCenter - Henning 907 Marshall Avenue, PO Box 57 Henning, Minnesota 56551

RE: Project Number S5540026

Dear Ms. Gedde:

On March 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 10, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On March 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 24, 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 February 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 10, 2016, effective March 21, 2016 and therefore remedies outlined in our letter to you dated March 1, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	'ISIT
	A. Building B. Wing	,	Y 2	3/31/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - HE	ENNING	907 MARSHALL AVENUE, PO BOX 57			
		HENNING, MN 56551			

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).

ITE Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0241	Correction	ID Prefix	F0242		Correction	ID Prefix	F0279		Correction
Reg. #	483.15(a)	Completed	Reg. #	483.15	(b)	Completed	Reg. #	483.20(d), 483.20)(k)(1)	Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			03/21/2016
ID Prefix	F0282	Correction	ID Prefix	F0313		Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	(b)	Completed	Reg. #	483.25(c)		Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			03/21/2016
ID Prefix	F0329	Correction	ID Prefix	F0371		Correction	ID Prefix	F0428		Correction
Reg. #	483.25(I)	Completed	Reg. #	483.35	(i)	Completed	Reg. #	483.60(c)		Completed
LSC		03/21/2016	LSC			03/21/2016	LSC			03/21/2016
ID Prefix	-	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.65	Completed	Reg. #			Completed	Reg. #			Completed
LSC		03/21/2016	LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) GL/mm	DATE 04/05/2	2016	SIGNATURE OF	SURVEYOR 34088			DATE 03/31	1/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/10/2016					R ANY UNCORRECTED DEFICIENCI				YE	s 🗆 NO

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REV	'ISIT
245540 _{Y1}	B. Wing	Y2	3/24/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - HI	ENNING	907 MARSHALL AVENUE, PO BOX 57		
		HENNING, MN 56551		

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).

ITE Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0017	02/23/2016	LSC	K0050		02/10/2016	LSC	K0052		02/11/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	101	Completed	Reg. #	NFPA 101		Completed
LSC	K0062	02/10/2016	LSC	K0070		03/21/2016	LSC	K0072		02/10/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0130	03/21/2016	LSC	K0144		02/09/2016	LSC	K0147		03/21/2016
ID Prefix Reg. #	NFPA 101	Correction	ID Prefix	NFPA 1	01	Correction Completed	ID Prefix Reg. #			Correction Completed
LSC	K0154	02/10/2016	LSC	K0155		02/10/2016	LSC			
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
	ED BV	DEVIEWED BY	-		CICNATURE OF	CHRVEVOR	100		DATE	
STATE A		REVIEWED BY (INITIALS) TL/mm	DATE 03/24/2	016	SIGNATURE OF		088			1/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/9/2016					R ANY UNCORRECTED DEFICIENCI				YE	s 🗆 NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

Ms. Joan Gedde, Administrator Golden LivingCenter - Henning 907 Marshall Avenue, PO Box 57 Henning, Minnesota 56551

Re: Reinspection Results - Project Number S5540026

Dear Ms. Gedde:

On March 31, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 10, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DAT	E OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
00799 _{Y1}	B. Wing	Y2	3/31	1/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - HE	ENNING	907 MARSHALL AVENUE, PO BOX 57			
		HENNING, MN 56551			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix 203	302		Correction	ID Prefix	20555		Correction	ID Prefix	20565		Correction
	State Statute		Completed	Reg. #	MN Ru Subp.	le 4658.0405 1	Completed	Reg. #	MN Rule 4658.0 Subp. 3	405	Completed
LSC			03/31/2016	LSC			03/31/2016	LSC			03/21/2016
ID Prefix 209	900		Correction	ID Prefix	21100		Correction	ID Prefix	21390		Correction
	Rule 4658.05	525	Completed	Reg. #	MN Ru Subp. !	le 4658.0650	Completed	Reg. #	MN Rule 4658.0 Subp. 4 A-I	800	Completed
LSC	.,		03/21/2016	LSC			03/31/2016	LSC			03/31/2016
ID Prefix 214	126		Correction	ID Prefix	21535		Correction	ID Prefix	21540		Correction
Dag # MN	St. Statute 14	14A.04	Completed	Reg. #	MN Ru	le4658.1315	Completed	Reg. #	MN Rule 4658.1	315	Completed
LSC Sub	od. 3		03/31/2016	LSC	Subp.1	ABCD	03/21/2016	LSC	Subp. 2		03/21/2016
ID Prefix 218	205		Correction	ID Prefix	01000		Correction	ID Prefix			Correction
-	St. Statute 14	14 651	Correction			Statute 144.651	Correction	ID FIEIIX			Correction
	od. 5	+4.031	Completed	Reg. #	Subd.		Completed	Reg. #			Completed
LSC			03/21/2016	LSC			03/21/2016	LSC			-
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			_	LSC			-
										1	
REVIEWED E STATE AGEN	ICY 💢	REVIEW (INITIAL:	ED BY S) GA/mm	DATE 04/05/2	2016	SIGNATURE OF		34088		DATE 03/3	1/2016
REVIEWED E	ЗҮ	REVIEW (INITIAL:	ED BY	DATE		TITLE				DATE	•
FOLLOWUP TO SURVEY COMPLETED ON 2/10/2016					L R ANY UNCORRE CTED DEFICIENC				 = YE	s □ no	

Page 1 of 1 EVENT ID: 5RL312



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 13, 2016

Ms. Joan Gedde, Executive Director Golden LivingCenter Henning 907 Marshall Avenue, P. O. Box 57 Henning, Minnesota 56551

Subject: Golden LivingCenter Henning - IDR

CMS Certification Number (CCN#): 24 5540

Project # S5540026

Dear Ms. Gedde:

This is in response to receipt dated March 4, 2015, of your request for an informal dispute resolution (IDR) for the federal deficiency identified at tag F314 issued pursuant to the survey event 5RL311, completed on February 10, 2016. The information presented with your letter, the CMS 2567 dated February 10, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

The information contained in written documentation presented by your facility for this IDR, the CMS 2567 dated February 10, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F314 S/S - G 42 CFR §483.25 (c) Pressure Ulcers: Based on a comprehensive assessment of a resident, that—

- (1) 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
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Summary of the facility's reason for IDR of this tag:

The facility indicates the requirements under 483.25(c) were met because they assert they had assessed, care planned and implemented care for this resident. The IDR request indicates the facility completed ongoing assessments appropriately, with frequent physician communication regarding the status of the resident and the pressure ulcer. The facility asserts they had assessed the pressure ulcer and revised the care plan appropriately. The facility also asserts the worsening of the resident's pressure ulcer was a result of co-morbid conditions and Prednisone (a corticosteroid medication) treatment. The facility requests the citation be removed or alternatively be changed to scope and severity level of F.

Summary of facts:

R37 was admitted to the facility on 8/6/15, and was assessed to have a Stage II area on the right buttock that measured 2.1 cm (centimeters) x 2.2 cm x 0.1 cm and a discolored area on the coccyx that measured 10 cm x 15 cm. The resident was placed on a side to side reposition schedule and provided with an alternating pressure air mattress. Because the resident was confined to bed upon admission, there were no care plan interventions developed for positioning the resident in a chair, nor assessment of chair sitting as it related to the resident's pressure ulcer. The care plan indicated the resident was to be turned and repositioned every two hours.

A progress note dated 9/3/15, indicated R37 could get up in a recliner wheelchair (w/c) once a shift every day and be left up for ½ hour. The note further indicated R37 was to be propped with pillows for positioning. There is no evidence the facility revised the resident's care plan at that time to indicate how long the resident could remain in a sitting position while she had a pressure ulcer. By 9/11/15, progress notes indicated the resident was sitting up in a chair for at least 90 minutes on one occasion. Progress notes continued to indicate R37 was up in the chair for up to 2.5 hours at a time. In addition, not all progress notes indicated the length of time she was up in the recliner chair. There was still no assessment conducted or care plan interventions developed to indicate how long R37 should have been up in the chair.

On 10/15/15, physician orders were received to start Prednisone. There was no indication the facility had considered this medication change as a possible reason to alter the resident's care plan related to her pressure ulcer until after the resident experienced a deterioration of the pressure ulcer.

Progress notes on 10/19/15, quoted the original therapy instructions to get R37 up in a recliner wheelchair once a shift every day for a half hour. The notes indicated the resident had complained of a "sore bottom" so would be left in bed and positioned side to side. There was no indication the resident's skin had been reassessed at that time, and on the following day 10/20/15, the resident was once again up in the wheelchair. Progress notes indicated R37's buttocks were "dark" and the medical director was notified. However there was no documented assessment or measurement of the area until 10/22/15, when it was identified as a shear/pressure wound measuring 6 cm x 9 cm x 0.1 cm and was pink in color.

The pressure ulcer continued to deteriorate over the next two months until the resident was sent to the hospital to have the area debrided on 12/16/15. After the ulcer was debrided, it was assessed as a Stage IV pressure ulcer. By the time of the survey in 2/16, as documented on the CMS 2567, the resident required a colostomy to divert stool from the rectum so a wound vac could be placed. The resident had a wound vac, was confined to bed, and was to be repositioned hourly from side to side. Surveyor observations and staff interview revealed the care plan was not implemented as written. The resident was not turned and repositioned for a period of almost three hours on 2/8/16.

A review of facility documents by the surveyor, and additional supervisory review to complete this IDR, revealed many weeks when the pressure ulcer was not assessed in order to determine if treatment was adequate or if the care plan required revision.

Summary of findings:

The facility failed to reassess and monitor the resident's pressure ulcer for an extended period of time after admission. They did not reassess in order to revise the care plan when new treatments were started such as sitting in a chair and the addition of a corticosteroid to her medication regimen. Although the facility had identified the addition of the corticosteroid could negatively impact wound healing, there was no indication there had been increased observation or assessment of the wound after the medication therapy was initiated. In addition, the facility did not immediately assess the resident's wound in an effort to determine whether the plan of care required revision even after R37 had complained of pain in the wound area.

After the resident was determined to have a Stage IV pressure ulcer, the facility did not always implement the plan of care as evidenced by the extensive period of time the resident was observed to be not repositioned on 2/8/16.

Non-compliance is based on the failure of the facility to reassess and monitor the pressure ulcer in a timely and consistent manner, failure to revise the care plan based on reassessment, and failure to implement the care plan as written.

As a result of this review, no modifications will be made to the details in the CMS 2567. The deficiency is valid as written and remains at a scope and severity of G, an isolated deficiency that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gayle Lantto, Unit Supervisor

Hayle Lantto

Licensing and Certification Program

Health Regulation Divison

Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651)201-3794

cc: Office of Ombudsman for Long-Term Care

Mary Absolon, Program Manager

Maria King, Assistant Program Manager Pam Kerssen, Assistant Program Manager

Gail Anderson, Fergus Falls Unit Supervisor

Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5RL3

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

	HE STATI	E SURVEY	AGENCY		Facili	ity ID: 00799			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245540 2.STATE VENDOR OR MEDICAID NO. (L2) 438670100		3. NAME AND ADI (L3) GOLDEN LI (L4) 907 MARSH. (L5) HENNING, M	VINGCENTER - ALL AVENUE, 1	- HENNING		L6) 56551	1. Initial 3. Termin 5. Validat	nation 4	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNE (L9) 04/01/2006	RSHIP	7. PROVIDER/SUF	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site 8. Full Su	e Visit irvey After Compla	9. Other
6. DATE OF SURVEY 02/10/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE		AR ENDING DAT	TE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	42 (L18) 42 (L17)	X B. Not in Com	nce With quirements	n	2. 3. 4.	Technical Personnel 24 Hour RN 7-Day RN (Rural SI Life Safety Code **B**	7. M NF) 8. Pa	irements: cope of Services Medical Director atient Room Size eds/Room	Limit
18 SNF 18/19 SNF 42 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)			1) or 1861 (j) (1):	(1	L15)	
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			~		Meath		Date:
Denise Erickson, HFE NEII			03/24/2016	(L19)		Enforceme	nt Specialist		03/25/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE C	OR SINGLE ST	ATE AGENCY		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partici 2. Facility is not Eligible	pate (L21)		IPLIANCE WITH C	CIVIL	21.		ancial Solvency (HCF rol Interest Disclosure ye:		13)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEM	ENT	26. TERMI	INATION ACTION:	:	(L30))
OF PARTICIPATION 04/01/1990	BEGINNING	DATE	ENDING DAT	E	VOLUNTAE 01-Merger, C	_		INVOLUNTARY 05-Fail to Meet H 06-Fail to Meet A	Health/Safety
(L24)	(L41)		(L25)			voluntary Termination	on		rgreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		04-Other Rea	ason for Withdrawal		OTHER 07-Provider Statu 00-Active	us Change
	B. Resema Sas	pension Bate.	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	KS			
		00454							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	TE					
	(L32)			(L33)	DETERM	INATION APPI	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 1, 2016

Ms. Joan Gedde, Administrator Golden LivingCenter - Henning 907 Marshall Avenue, PO Box 57 Henning, Minnesota 56551

RE: Project Number S5540026

Dear Ms. Gedde:

On February 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 21, 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 March 21, 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 May 10, 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 August 10, 2016 (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 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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		245540	B. WING _		2/10/2016
	PROVIDER OR SUPPLIER	NNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 COMMENT	-S	F 00	0	
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 aic submission of the POC will ion of compliance.			
F 241 SS=D	on-site revisit of you validate that substate regulations has been your verification.	Upon receipt of an acceptable electronic 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. 483.15(a) DIGNITY AND RESPECT OF		.1	3/21/16
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.			
	by: Based on observate review, the facility for dignity during leisure for 1 of 3 residents gait belt for ambulate. Findings include: R24's quarterly Min 11/18/15, identified impairment, requires	Based on observation, interview, and document eview, the facility failed to ensure personal ignity during leisure activities and meal service or 1 of 3 residents (R24) observed to utilize a ait belt for ambulation. indings include: 124's quarterly Minimum Data Set (MDS) dated 1/18/15, identified R24 had moderate cognitive inpairment, required extensive assistance from taff for personal hygiene, dressing, toileting and		It is the intent of Golden Living-Henning to treat our residents with dignity and respect. For (R24) education was provided immediately to nursing staff about appropriate use of gait belt and that it should not remain on a resident while at meals, leisure activities or while lying down. All residents have the potential to be affected by the deficient practice. Facility staff from all departments including managers have been educated	
ABORATORY	Z DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE	(X6) DATE

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

Electronically Signed

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.

03/10/2016

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245540	B. WING _		02/	10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP COI 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	8/28/15, identified of cerebral vascular and depression, and had pression, and had R24's current care R24 had visual deficit and had phy plan listed various staff assistance with and walker related encourage choices and guidance. Observations on 2/ - At 3:55 p.m. R24 nursing assistant (I wheeled walker and around his/her waistationary chair, at The blue gait belt his/her waist. R24 napkin/clothing procups of fluids with I the table in front of -At 5:27 p.m. NA-E explained coffee, cowere available on the -At 5:29 p.m. NA-E assisted other residuations and control of the	ssessment (CAA) dated diagnoses which included accident, blindness, and of hearing. plan revised 1/28/16, identified icit due to blindness, hearing resical impairments. R24's care interventions which included th ambulation with a gait belt to blindness, explain cares, with cares, offer verbal cues (8/16, identified the following: 4 was assisted to walk by NA)-E. R24 walked with a d wore a dark blue gait belt st. was observed seated in a a table in the dining room. remained fastened around had a brown cloth otector on his/her chest, and handles and straws were on	F 24	on what dignity and respect is treat residents with dignity and March 3rd and March 8th. A session will be held March 15 staff not able to attend the first meetings. Weekly audits will be conduct shifts for four (4) weeks follow other week audits for four (4) random audits conducted as a necessary thereafter. Audits will be conducted by D designee. All findings will be reviewed m QAPI. Corrective action to be compl 3/21/2016.	d respect on make-up th for any st two ed on all wed by every weeks; with deemed	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		E SURVEY MPLETED	
		245540	B. WING _	 	02/	10/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - HI	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 241	- At 5:46 p.m. the faevening meal. -At 5:46 p.m. NA-A the dining table. NA explaining where it and bowls of foods directly into R24's remained fastened throughout the every case of the second of th	round his/her waist. acility Dietitian delivered R24's sat to the right side of R24 at A-A assisted R24 with eating, ems were, handing utensils to R24 and spooning foods mouth. The dark blue gait belt around R24's waist ning meal service. turned R24's stationary chair e, placed the wheeled walker assisted him/her to stand. It was walk through the dining grasp the gait belt to assist instead held on to the front wheeled walker, and then the walker until R24 had reached grasped the gait belt and he bathroom without the use	F 24				

-	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245540	B. WING		02	2/10/2016		
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, 907 MARSHALL AVENUE, PO HENNING, MN 56551	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 241	dining room betweer resident who was id friend. The dark blu around R24's wais the bingo game whip.m. On 2/08/16, at 6:28 the gait belt on thro R24 currently conting while laying in bed. gait belt remaining NA-A stated "[R24] hour." NA-A indicated have the gait belt fan NA-A indicated at the front lobby with time the gait belt was "[R24] has never congait belt for extended Observations on 2/9 -At 2:54 p.m. NA-F the hall from his/he cookies and coffee stationary chair and gait belt remained for through the snack at -At 3:46 p.m. R24 with stationary chair by the dark blue gait is waist.	vas seated at a table in the en the bingo caller and a dentified by R24 as a personal regait belt remained fastened at throughout the observation of ich was completed at 7:51 B p.m. NA-A verified R24 had ughout the evening meal, and nued to have the gait belt on When questioned about the fastened around R24's waist will go down to bingo in a half red that R24 did not always astened around his/her waist. The image is a female resident and at that as loosened. NA-A stated omplained about wearing the red periods of time. B/16, identified the following: Tassisted R24 to walk down room to the dining room for NA-F seated R24 in a left the room. The dark blue astened around R24's waist	F 2	241				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245540	B. WING			02 /-	10/2016
	PROVIDER OR SUPPLIER	ENNING		90	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MARSHALL AVENUE, PO BOX 57 IENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	provide safety. NA-while at the facility; possibly may go ou NA-B identified it was practice to leave a gresident's waist wheresident. NA-B verification of the very been removed where dining room. On 2/09/16, at 12:5 belts should be removed where waist anytime where on 2/09/16, at 3:48 a gait belt on at this visiting with a femal R24 utilized a gait belt walking. NA-G indicated around R2 and stated "I take it is at the table." On 2/10/16, at 7:12	assist with walking and to B indicated R24 had not fallen however, had a knee that t and R24 saw only shadows. as not the usual facility gait belt fastened around a en not walking with the fied the gait belt should have n R24 was seated in the	F 2	41			
	R24 stated staff had belt around R24's w	vould remain in place all day. d not asked if leaving the gait vaist bothered [R24]." R24 book like hell, I can't see to take					
F 242 SS=D	reviewed 1/26/15, c belt; however, the p the gait belt was to	tled Transfer Activities, directed staff with use of a gait policy did not address when be removed. ETERMINATION - RIGHT TO	F 2	42			3/21/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245540	B. WING			02/1	10/2016
	PROVIDER OR SUPPLIER	ENNING		90	REET ADDRESS, CITY, STATE, ZIP CODE 7 MARSHALL AVENUE, PO BOX 57 ENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 242	schedules, and hea her interests, asses interact with membrinside and outside to about aspects of his are significant to the This REQUIREMENT by: Based on interview facility failed to accepte ferences for bath R11) reviewed for buth Findings include: R30 indicated on 2/received a bath two really should have a incontinence of loose R30's quarterly Min 1/18/16, identified Frequired extensive mobility, toilet use, was frequently incount The physician progridentified diagnoses diarrhea, and colon Review of the facility through February 9 baths a week, Thur On 2/10/16, at 8:47	e right to choose activities, alth care consistent with his or asments, and plans of care; ers of the community both he facility; and make choices is or her life in the facility that eresident. AT is not met as evidenced and document review, the commodate resident hing for 2 of 2 residents (R30, eathing preferences. AT is not met as evidenced and document review, the commodate resident hing for 2 of 2 residents (R30, eathing preferences. AT is not met as evidenced and document review, the commodate resident hing for 2 of 2 residents (R30, eathing preferences. AT is not met as evidenced in and document review, the commodate resident hing for 2 of 2 residents (R30, eathing preferences. AT is not met as evidenced incontinence, cancer. AT is not met as evidenced incontinence, cancer.	F 2	42	F 242 It is the intent of Golden Living-Herhonor all residents' right to self-determination (right to make chesidents #30 and #11 have been interviewed regarding bathing preferences, and are receiving bath choice. All residents have the potential to baffected by the deficient practice. Current residents have been intervito determine bathing preferences. Resident's bathing preferences are addressed upon admission and reviquarterly and as indicated. Reside receiving baths per preferences. Expreferences are placed on a bathing sheet for CNA use daily. Staff has been educated on providibathing per resident preferences to include any request for additional be Monitoring to ensure compliance, the DNS/designee will conduct random weekly audits/resident interviews the baths are being provided per reside preference. The results of the audits will be rev	noices). Ins per iewed iewed ints are Bathing ing ing inths. ine inat ent	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245540	B. WING			02/	10/2016
_	PROVIDER OR SUPPLIER	ENNING	STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	on Sundays and Thresidents asked for fulfill the request or shift. NA-D stated " [he/she] could have most times can't." Neginning of Novemhowever, R30 was	age 6 hursdays. NA-D identified if additional baths staff tried to awould pass it on to the next [R30] tells me [he/she] wished a bath every day,we try but NA-D identified since the aber staffing had been cut; not given more baths prior to sheduled. NA-D stated "We	F 2	42	monthly in QAPI.		
	received a bath one told them I would like have too many peo	12:00 p.m. identified he/she ce a week. R11 stated "I have ke more and they said they ple." R11 indicated he/she se and the bath aide to request n per week.					
	identified diagnoses	rogress note dated 11/24/15, s which included super-morbid bility, peripheral neuropathy, ease and diabetes.					
	11/27/15, identified required extensive mobility, toilet use,	MDS assessment dated R11 had intact cognition, and assistance with transfers, hygiene and dressing, was ent of bowel and bladder, and tance with bathing.					
	was frequently inco and received a bath the bath schedule F	ant care sheets identified R11 ontinent of bowel and bladder on Wednesdays. Review of February 1 through February 9, eived one bath a week, on					
		55 a.m. NA-B identified R11 nto the bathroom to wash.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245540	B. WING _		02/10/2016	
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 242	NA-B indicated R11 towel to wash daily time a week. On 2/10/16, at 8:31 worker (LSW)-F ide resident bathing schurses scheduled by preferences. LSW-with bathing was to of tub baths versus the choice is to the on the MDS. On 2/10/16, at 11:3 nursing (ADON) ide was initiated upon a however, if a reside baths staff would trirequest. The ADON	ge 7 was given a wash cloth and a and received a tub bath one a.m. The licensed social entified she did not coordinate hedules. LSW-F indicated the bathing and reviewed F identified her involvement inquire resident preferences showers and how important resident, for documentation 3 a.m. the assistant director of entified a bathing schedule admission to the facility; and voiced a request for more y to accommodate the I indicated being unaware R30 equests for more baths.	F 24	2		
F 279 SS=D	(DON) identified ea or shower per week issues or a request The DON stated "If make every effort to Don verified the use honor resident requested facil 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to	ity policy was not provided. (1) DEVELOP CARE PLANS he results of the assessment and revise the resident's	F 27	9		3/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245540	B. WING			02/10/2016	
	PROVIDER OR SUPPLIER			907 N	ET ADDRESS, CITY, STATE, ZIP CODE IARSHALL AVENUE, PO BOX 57 NING, MN 56551	,	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	The facility must deplan for each reside objectives and time medical, nursing, a needs that are identificated assessment. The care plan must to be furnished to a highest practicable psychosocial well-lights specificated as the required under due to the resident \$483.25; and any side required under due to the resident \$483.10, including under \$483.10 (b) (a) This REQUIREMED by: Based on observative review, the facility include appropriate hearing for 1 of 1 mearing. Findings include: R24's quarterly Min 11/18/15, identified impairment, ability normally used with required speaker to distinctly, required for personal hygier Area Assessment diagnoses which in the same and	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial of tified in the comprehensive at describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment	F 2	Fit has foo (Fine property pro	is the intent of Golden Living-Herave to have a comprehensive carar each resident. R 24) care plan has been reviewed as indicated regarding the earing aids per resident's personate ference. Wo additional residents have the otential to be affected by the deficitant care plans have been revind revised as indicated that terventions to assist with hearing ace. Staff has been educated on odating care plans with hearing are sion interventions.	e plan d and use of al iient iewed are in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245540	B. WING		02/	10/2016
	PROVIDER OR SUPPLIER	ENNING	9	STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	, ,	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	identified R24 had communication due preferred to wear or directed staff to ensign and functioning; ho direct conversation in place. During the initial int R24 was asked if sign decisions about you treatments? R24 stoof anything. I think don't want me to know about." During the evening p.m. to 6:12 p.m. Rearing aid in the learning aid not make an effills your hearing aid R24 a bowl of soup it up to his/her mouth. NAcueing R24 to eat, not have the hearing Cn 2/09/16, at 8:4 (LPN)-B approaches white paper cup. Lear and placed the	plan revised 1/28/16, blindness, impaired to impaired hearing, nly one hearing aid and sure hearing aid was in place wever, did not specify staff to to the ear with the hearing aid review on 2/7/16, at 4:08 p.m. taff included him/her in ur medicine, therapy, or other tated,"They don't tell me much they whisper sometimes, they now what they are talking meal on 2/08/16, from 5:46 (24 was observed to have a left ear. Nursing assistant on the right side of R24. NA-A ting utensil and explained tems were placed on the table. It response to NA-A, and R24 fort to feed self. NA-A stated working?" and then handed to R24 accepted the bowl, held the and spooned soup into A was observed repeatedly speaking to the ear that did ag aid throughout the meal.	F 279	DNS/designee will conduct randoweekly audits of care plans compliance care observation that care interventions are in place. The results of the audits will be rat the QAPI meeting monthly. Corrective action will be comple 3/21/2016.	pared to e planned eviewed	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245540	B. WING _		02	/10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP COE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	R24 did not respon was asked and with staff appeared to bhis/her head from swith a stern "no." On 2/09/16, at 2:5 walk down the from room for coffee and R24's right side tall hearing aid. On 2/08/16, at 6:2 wore one hearing a ear R24 wore the hR24 would be able with the hearing aid utilized R24's right attempt to commun confirmed R24's leattempt to commun of it." On 2/09/16, at 10: although R24 did hears, R24 was able and R24 chose to the left ear. On 2/10/16, at 7:12 wore only one hear adequately if it was loudly. R24 stated by the staff of	age 10 ag more to drink was needed. d the first time the question a repeated questioning from ecome agitated. R24 shook side to side and responded 4 p.m. NA-F assisted R24 to a R24's room to the dining d cookies. NA-F walked on king to the ear without the 8 p.m. NA-A verified R24 only id, but was not aware which earing aid in. NA-A agreed to hear better out of the ear d. NA-A confirmed he/she had ear, without the hearing aide to hicate with R24. NA-A it ear had not been used to hicate and stated "I didn't think 45 a.m. NA-B indicated ave a hearing aid for both to hear better with the left ear wear the hearing aid only in 2 a.m. R24 identified he/she ing aid and was able to hear quiet and the speaker spoke They should know I hear with aring aid. The other ear is no	F 27	79		
		p.m. the director of nursing would expect staff to speak				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245540	B. WING		02/10/2016	
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
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F 279	DON indicated R24 hearing aid and need appropriately should	R24 wore the hearing aid. The s's preference for wearing the ed to use the hearing aid d should have been he staff in order for staff to be	F 27	9		
F 282 SS=D			F 28	2		3/21/16
	by: Based on observatoreview the facility fainterventions for po (R37) reviewed for Findings include: Review of R37's caidentified R37 had a care plan identified staff to turn and rep R37's care plan list pressure relieving r	ion, interview and document illed to implement care plan sitioning for 1 of 2 residents pressure ulcers. re plan dated 8/24/15, a current pressure ulcer. R37's R37 required assistance of 2 position every 1-2 hours. Ped various interventions of a mattress and to complete essments on R37's pressure		F 282 It is the intent of Golden Living-Her provide cares per care plan by appropriately trained staff. Resident #37 care plan has been reviewed and revised as indicated to turning and repositioning, and cabeing provided per care plan. Complete tissue tolerance observa current residents to determine posi needs and care plan as appropriate Residents are receiving care per caplan for repositioning. Staff has been educated on providi care for residents per care plan. Monitoring to ensure compliance, the DNS/designee will conduct random	related are is tion for tioning e. are ng	

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 282	On 2/8/16, during c 3:56 p.m. to 6:26 p. bed on her right sid assisted to reposition observation. - At 3:56 p.m. R37 bed with an air alter had a book in her hroom lights were or - At 4:15 p.m. R37 bed, had set her body bed, had set her body bed. The sociton enter R37's room R37 opened her eyleft the room, R37 on her right side. - At 5:24 p.m. R37 right side, covers up assistant (NA)-A ward R37's room. NA-A or repositioning. R37 uping in bed. - At 5:35 p.m. regis into R37's room, as colostomy bag whill side. RN-B adminis fluid flushes via gas hooked up R37's tu head of bed. RN-B	ontinuous observations from m., R37 was observed lying in the without being offered, or on during the entire. was lying on her right side in mating mattress in place. R37 ands, eyes were open and the mok on the bed and closed her observed to offer assistance. The mained lying in bed on her all worker (SW) was observed in and spoke briefly with R37, we and nodded. The SW then closed her eyes and remained lying in bed on her put to mid torso. Nursing alked down the hallway, past did not offer R37 assistant with remained on her right side tered nurse (RN)-B walked sisted to empty R37's was read to offer R37 was not observed to offer R37 was not observed to offer R37 was not observed to offer R37 is left R37's room at 5:44 p.m.,	F 282	weekly audits/direct care observant cares that re-positioning is provided per care plan. The results of the audits will be in QAPI.	being		

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		245540	B. WING _		02	/10/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		, 10, 2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	right side with eyes up to her torso. No assistance with report of the control of	remained lying in bed on her closed and a blanket covered staff was observed to offer	F 28	2			
	had a current stage indicated R37 was	high. The DON confirmed R37 e 4 sacral pressure ulcer and on a every hour side to side am. The DON and RN-B					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CO 907 MARSHALL AVENUE, PO BOX 5 HENNING, MN 56551	DDE	
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F 282	assisted R37 to her pillows covered in calternating pressure bilateral tan colored heels. On 2/8/16, at 6:36 prequired assistance side to side to prev The DON confirme pressure ulcers. The lay on her back and stage 4 pressure ulstated she was unsrepositioned as ord and ostomy nurse (she expected staff reposition side to sverified R37 had lap.m. The DON veri right side for a total On 2/8/16, at 6:53 pursing (ADON) starting and control of the pillows of	r left side and positioned dry pillow cases. R37 had an elemattress in place and had defended heel protectors on both co.m. the DON stated R37 effor repositioning every hour ent further skin breakdown. d R37 was at high risk for the DON stated R37 was not to do was bedridden due to the cer on her sacrum. The DON stated by the certified wound (CWON). The DON stated to assist R37 to turn and dide every hour. The DON stated to assist R37 to turn and dide every hour. The DON stated to assist R37 to turn and dide every hour. The DON stated to assist R37 had remained on her of 2 hours and 56 minutes.	F 28	32		
	to reposition R37 si prevent further skir	de to side every hour to breakdown/pressure ulcers when abrasions were noticed				
	stated she had last p.m. NA-E stated s every 2 hour reposit	o.m. nursing assistant (NA)-E repositioned R37 around 3:30 he understood R37 was on a tioning schedule and stated R37 was supposed to be hour.				
	assisted R37 to rep	o.m. NA-A stated he had not position since about 3:30 p.m. as supposed to be repositioned				

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	NNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
every 1-2 hours. NA assist R37 with reporesidents had need R37 had not been r 6:26 p.m. a total of Review of the facilit Status, Additional A Plan of Care (IPOC indicated an resider completed. In additi were checked on th indicated the need to section. 483.25(b) TREATM HEARING/VISION To ensure that resident and assistive device hearing abilities, the assist the resident i by arranging for trait office of a practition treatment of vision of treatment of vision of treatment of vision of this REQUIREMEN by: Based on observat review, the facility fa services related to ta appropriately for 1 of	A-A stated staff were unable to ositioning because other ed assistance. epositioned from 3:30 p.m. to 2 hours and 56 minutes. y policy titled Clinical Health ssessments and Immediate) with a review date of 5/3/15, at assessment was to be on, if any blue shaded boxes to Clinical Health Status it for IPOC related to the ENT/DEVICES TO MAINTAIN dents receive proper treatment the stomaintain vision and the facility must, if necessary, in making appointments, and insportation to and from the er specializing in the or hearing impairment or the onal specializing in the or hearing assistive devices. AT is not met as evidenced ion, interview and document ailed to provide the necessary the use of a hearing device		F 313 It is the intent of Golden Living-Henrensure residents have appropriate treatments/devices to meet vision a		
Findings include:			hearing loss per personal preference		
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa every 1-2 hours. NA assist R37 with reported residents had need R37 had not been r 6:26 p.m. a total of Review of the facilit Status, Additional A Plan of Care (IPOC indicated an resider completed. In additiver checked on the indicated the need of section. 483.25(b) TREATM HEARING/VISION To ensure that resident in the indicated the resident in the indicated in its paranging for train office of a practition treatment of vision of indicated the indicated	PROVIDER OR SUPPLIER LIVINGCENTER - HENNING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 every 1-2 hours. NA-A stated staff were unable to assist R37 with repositioning because other residents had needed assistance. R37 had not been repositioned from 3:30 p.m. to 6:26 p.m. a total of 2 hours and 56 minutes. Review of the facility policy titled Clinical Health Status, Additional Assessments and Immediate Plan of Care (IPOC) with a review date of 5/3/15, indicated an resident assessment was to be completed. In addition, if any blue shaded boxes were checked on the Clinical Health Status it indicated the need for IPOC related to the section. 483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary services related to the use of a hearing device appropriately for 1 of 1 residents (R24) reviewed for hearing.	PROVIDER OR SUPPLIER LIVINGCENTER - HENNING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 every 1-2 hours. NA-A stated staff were unable to assist R37 with repositioning because other residents had needed assistance. R37 had not been repositioned from 3:30 p.m. to 6:26 p.m. a total of 2 hours and 56 minutes. Review of the facility policy titled Clinical Health Status, Additional Assessments and Immediate Plan of Care (IPOC) with a review date of 5/3/15, indicated an resident assessment was to be completed. In addition, if any blue shaded boxes were checked on the Clinical Health Status it indicated the need for IPOC related to the section. 483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary services related to the use of a hearing device appropriately for 1 of 1 residents (R24) reviewed for hearing.	SUMMARY STATEMENT OF DEFICIENCIES PROVIDER OR SUPPLIER	

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		245540	B. WING		02/	10/2016
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F 313	R24's quarterly Mir 11/18/15, identified impairment, ability normally used with required speaker to distinctly, required for personal hygien Area Assessment (diagnoses which in accident, blindness hearing. R24's current care identified R24 had communication due preferred to wear of directed staff to enand functioning; hod direct conversation in place. During the initial introduced R24 was asked if secisions about you treatments? R24 si of anything. I think don't want me to know the aring aid in the know the conversation in place. During the evening p.m. to 6:12 p.m. Fernaments are to know the conversation in place. During the evening p.m. to 6:12 p.m. Fernaments are to know the conversation in place.	simum Data Set (MDS) dated R24 had moderate cognitive to hear with hearing aid moderate difficulty, and increase volume and speak extensive assistance from staff e, and dressing. The Care CAA) dated 8/28/15, identified cluded cerebral vascular depression, and hard of plan revised 1/28/16, blindness, impaired to impaired hearing, any one hearing aid and sure hearing aid was in place wever, did not specify staff to to the ear with the hearing aid erview on 2/7/16, at 4:08 p.m. taff included him/her in the properties of the plan revised 1/28/16, at 4:08 p.m. taff included him/her in the properties of the plan revised 1/28/16, at 4:08 p.m. taff included him/her in the properties of the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the properties of the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the properties of the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the properties of the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in the plan review of 2/7/16, at 4:08 p.m. taff included him/her in taff	F 313	All other residents identified as n assistance with vision and hearin receiving assistance per care plater personal preference. Staff has been educated on provicare to residents related to hearing vision, based on care plan and preference. Care plans and CNA sheets have been updated to refindividualized needs of the reside Monitoring to ensure compliance DNS/designee will conduct randoweekly audits/care observations interventions are in place for visite hearing. The results of the audits will be not the QAPI meeting monthly.	ig, are in and iding ing and ersonal care ect ents. , the om that on and	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HENNING				STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
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F 313	R24 a bowl of soup. R24 accepted the bowl, held it up to his/her mouth and spooned soup into his/her mouth. NA-A was observed repeatedly cueing R24 to eat, speaking to the ear that did not have the hearing aid throughout the meal. On 2/09/16, at 8:47 a.m. licensed practical nurse (LPN)-B approached R24 with medications in a white paper cup. LPN-B spoke in to R24's right ear and placed the medicine cup in R24's hand. LPN-B asked R24 while speaking in to his/her right ear if something more to drink was needed. R24 did not respond the first time the question was asked and with repeated questioning from staff appeared to become agitated. R24 shook his/her head from side to side and responded with a stern "no." On 2/09/16, at 2:54 p.m. NA-F assisted R24 to walk down the from R24's room to the dining room for coffee and cookies. NA-F walked on R24's right side talking to the ear without the hearing aid.		F 31	3			
	wore one hearing a ear R24 wore the h R24 would be able with the hearing aid utilized R24's right attempt to commur confirmed R24's leattempt to commur of it." On 2/09/16, at 10: although R24 did hears, R24 was able	B p.m. NA-A verified R24 only id, but was not aware which earing aid in. NA-A agreed to hear better out of the ear I. NA-A confirmed he/she had ear, without the hearing aide to nicate with R24. NA-A it ear had not been used to nicate and stated "I didn't think I didn't think I a.m. NA-B indicated ave a hearing aid for both to hear better with the left ear wear the hearing aid only in					

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F 313	Continued From page 18 the left ear. On 2/10/16, at 7:12 a.m. R24 identified he/she wore only one hearing aid and was able to hear adequately if it was quiet and the speaker spoke loudly. R24 stated "They should know I hear with the ear with the hearing aid. The other ear is no good." On 2/10/16, at 1:55 p.m. the director of nursing (DON) verified she would expect staff to speak into the ear which R24 wore the hearing aid. The DON indicated R24's preference for wearing the hearing aid and need to use the hearing aid appropriately should should have been communicated to the staff in order for staff to be aware of how to talk to R24.		F3	13		
F 314 SS=G	planing was not pro 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores for this REQUIREMENT.	ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and healing, prevent infection and from developing.	F 3			3/21/16
		ion, interview and document		F 314		

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F 314	review, the facility assess and failed of a worsening pre (R37) reviewed for the facility failed to interventions for 1 for pressure ulcers resulted in actual h 2 pressure ulcer wulcer. Findings include: Review of R37's quality (MDS) dated 1/25/cognitive impairmed included: encephal pressure ulcers. Totally dependent undaily living (ADL's. stage 4 (full thicknoone, tendon or moder be present on som Often includes undaily living (ADL's. stage 4 (full thicknoone, tendon or moders and pressure ulcer white (cm) long, 7.0 cm. MDS identified R3 worsened since the MDS listed pressure pressure relieving and repositioning pressure relieving and repositioning pressure relieving and had diagnoses encephalopathy, dencephalopathy, denceph	failed to comprehensively to conduct ongoing monitoring ressure ulcer for 1 of 2 residents pressure ulcers. In addition, implement repositioning of 2 residents (R37) reviewed at This deficient practice narm for R37, who had a stage rorsen to a stage 4 pressure at and had diagnoses which lopathy, dysphagia and he MDS identified R37 was upon staff for all activities of The MDS identified R37 had a ress tissue loss with exposed uscle. Slough or eschar may be parts of the wound bed. Idermining and tunneling chemical chemica	F3	114	It is the intent of Golden Living-Herensure appropriate treatment to prepressure ulcers and to treat or seel medical appointments for pressure that are acquired prior to admission Resident #37 care plan, assessme treatments, and documentation of have been reviewed and updated. No other residents with pressure ulthis time. Other resident identified with skin in at risk; care plans, assessments, treatments and documentation havereviewed and updated. The living center has reviewed and revised the Skin Integrity Program including skin assessments, care printerventions, treatments, and documentation of Skin Integrity. Licensed and non-licensed staff hat educated on the revised Skin Integrogram. Monitoring to ensure compliance, the DNS/designee will conduct random weekly audits/direct care observation that care is being provided per care documentation, and assessments a being completed per living center State of the audits will be reverted that QAPI meeting monthly.	event c ulcers n. nts, wounds cers at ntegrity e been lan s been rity he ons e plan, are skin	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	stage 2 (partial thic presenting as a shared-pink wound become present as an intact pressure ulcer. The interventions included pressure relieving of the staff to turn and repaired plan list pressure relieving results.	kness loss of dermis allow open ulcer with a d, without slough. May also t or open/ruptured blister) MDS listed pressure ulcer led: pressure ulcer care and a device for bed. essure ulcer Care Area dated 8/13/15, identified R37 sure ulcer. The CAA identified pressure ulcer development cal assistance with bed	F 3	314			
	3:56 p.m. to 6:26 p.	continuous observations from .m., R37 was observed lying in le without being offered, or on during the entire					
	bed with an air alte	was lying on her right side in rnating mattress in place. R37 ands, eyes were open and the n.					
	bed, had set her bo	remained on her right side in bok on the bed and closed her observed to offer assistance.					

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F 314	right side. The soc to enter R37's room R37 opened her ey left the room, R37 on her right side. - At 5:24 p.m. R37 right side, covers assistant (NA)-A w R37's room. NA-A repositioning. R37 lying in bed. - At 5:35 p.m. regis into R37's room, as colostomy bag whi side. RN-B adminis fluid flushes via ga hooked up R37's thead of bed. RN-B repositioning. RN-R37 remained on her torso. No assistance with registration of the color of th	remained lying in bed on her ial worker (SW) was observed in and spoke briefly with R37. Wes and nodded. The SW then closed her eyes and remained in remained lying in bed on her into mid torso. Nursing alked down the hallway, past did not offer R37 assistant with remained on her right side is sisted to empty R37's like R37 remained on her right stered R37's medications and stric tube (g-tube.) RN-B sube feeding and raised R37's was not observed to offer R37 is left R37's room at 5:44 p.m., her right side.	F3	114			

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F 314	and top sheets were peeled the blue incompeted the blue incompeter to the right edge of the upper right thigh. The areas were from a competer in use. R37's with a transparent of the wound vacuum special plastic tube was obstransparent dressing suction device with drainage from R37's skin was dar creases on her entishoulder to the bott stated she felt R37 from the linen, was blanchable redness buttocks, hip and the had a current stage indicated R37 was repositioning prograssisted R37 to help illows covered in calternating pressure bilateral tan colored heels. On 2/8/16, at 6:36 prequired assistance side to side to previous prograssisted to side to previous prograssisted to side to previous programments the pillows covered in calternating pressure bilateral tan colored heels.	s. R37's pillow case, fitted, lift e also damp/moist. The DON ontinent pad away from R37's pulled a layer of granulation m x 1 cm circular open area's f R37's right buttocks and he DON stated she felt these dhesive tape which was no sentire sacrum was covered dressing which held a black onge (wound vac) in place. A served from under the lag and was attached to a a canister which collected is stage 4 pressure ulcer. It is purple/ red in color with linentire right side (from the lom of her thigh.) The DON is skin had creases imprinted damp from sweat and had son her right side shoulder, high. The DON confirmed R37 is 4 sacral pressure ulcer and on a every hour side to side am. The DON and RN-B reft side and positioned dry pillow cases. R37 had an elemattress in place and had defined protectors on both	F3	14		
	pressure ulcers. The lay on her back and stage 4 pressure ul	d R37 was at high risk for the DON stated R37 was not to be was bedridden due to the locer on her sacrum. The DON sure why R37 was not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 314	repositioned as ord and ostomy nurse (she expected staff reposition side to siverified R37 had lasp.m. The DON verified reposition at the dispersion of the ADON stated to the accurrently being rout. The ADON stated reposition R37 side further skin breakdoweek ago when about a series and the accurrently being rout. The ADON stated R37 side further skin breakdoweek ago when about a series and the accurrent and repositioning prograstated R37's physical pressure ulcer and surgical debrideme ADON stated R37 had a sacrum. ADON stated R37 had a sacrum. ADON stated R37 had a sacrum and the sacrum and	ge 23 ered by the certified wound CWON). The DON stated to assist R37 to turn and de every hour. The DON st been repositioned at 3:30 fied R37 had remained on her of 2 hours and 56 minutes. o.m. the assistant director of sted R37's wound was inely evaluated by a CWON. The a CWON had directed to to side every hour to prevent own/pressure ulcers about a rasions were noticed on R37's ated she was the person who completion of the weekly s for R37. ADON stated R37 with a stage 2 pressure ulcer had been on a turn and arm of every 2 hours. ADON ian had evaluated R37's stage d identified R37 needed not of the pressure ulcer. The ada a surgical debridement of the ulcer on 12/15 which had a stage 4 pressure ulcer on her stage 5 pressure ulcer on her stage 6 pressure ulcer on her stage 7 pressure ulcer on her stage 8 pressure ulcer on her stage 9 pressure 9 p		114		

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F 314	worsened from a s stage 4 pressure u On 2/8/16, at 7:10 stated she had last p.m. NA-E stated severy 2 hour reposshe was unaware I repositioned every On 2/8/16, at 7:43 assisted R37 to repand stated R37 was every 1-2 hours. Nassist R37 with represidents had need R37 had not been 6:26 p.m. a total of On 2/10/16, at 7:36 pressure ulcer care and ADON present machine was obse R37's stage 4 sacr drainage collection contained reddish CWON verified R3 and foul smelling. I from R37's sacrum R37 had a increase edge of the current identified R37 had 2 cm from the oper was present from a o'clock position of felt R37 had been and had caused present as the stage of the current and the stage of the current identified R37 had a increase edge of the current identified R37 had a increase edge of the current identified R37 had a increase edge of the current identified R37 had a increase edge of the current identified R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a o'clock position of felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a felt R37 had been and had caused present from a	tage 2 pressure ulcer to a lcer. p.m. nursing assistant (NA)-E repositioned R37 around 3:30 the understood R37 was on a itioning schedule and stated R37 was supposed to be hour. p.m. NA-A stated he had not position since about 3:30 p.m. s supposed to be repositioned A-A stated staff were unable to positioning because other	F 314	4		

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F 314	wound had tunneling o'clock. CWON state pressure ulcer measure ulcer measure and was 3.5 chad superficial open her right buttocks a diameter. She also staff after the trans wound vac had been caused the new open CWON stated R37 blisters, one on each to the lift sheet bein CWON stated R37 in early February a	age 25 on. CWON stated R37's sacral ag present from 9 o'clock to 3 ated R37's stage 4 sacral asured 5.5 cm long x 6 cm cm deep. CWON indicated R37 on areas from adhesive tape on and thigh both were 2 cm in stated she had re-educated parent dressings used with the en applied incorrectly and the areas on the buttocks. Talso had two 2 cm diameter ch shoulder from shearing dueing kept under R37. The 's shearing areas were noted and a different lift sheet had and not arrived in facility at		4		
	from 8/6/15, to 12/2 -On 8/6/15, identifice the facility with a stabuttocks. The assessand pressure ulcer mand had 100% assessment identification from the ulcer pressure redistribution from 8/19/15, reveaulcer measured 2.1 had 100% epithelia from the assessment icon a pressure redistribution from the ulcer from 8/19/15, reveaulcer measured 2.1 had 100% epithelia from the assessment icon a pressure redistribution from the	eekly wound assessments 24/15, revealed the following: ed R37 had been admitted to age 2 pressure ulcer on the essment revealed R37's stage easured 2.1 cm x 2.2 cm x 0.1 epithelial tissue present. The ied current interventions of a tion mattress and barrier every shift. led R37's stage 2 pressure I cm x 2.1 cm x 0.1 cm and all (definition)tissue present. Itentified current interventions tribution mattress, barrier and repositioning program of				

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F 314	pressure ulcer. The was admitted with a become worse and surgical debrideme. The assessment re ulcer measured 8.2 red with 75% grant granular form on at of a wound) tissue, yellow, tan, gray, granular form on at of a wound or prese wound bed,)tissue of serosanguineou amounts of blood) revealed the skin sulcer was macerate undefined. The ass tunneling or odor widentified current in redistribution mattribution mattribut	tified R37 had a stage 4 sacral assessment revealed R37's a pressure ulcer which had required hospitalization for a nt of the sacral pressure ulcer. Evealed R37's stage 4 pressure etcm x 8.6 cm x 5.1 cm, was allation (new vascular tissue in nulcer or the healing surface 25% slough (non-viable reen or brown tissue; usually stringy and mucinous in y be adherent to the base of ent in clumps throughout the and had a moderate amount as (yellowish serum with small drainage. The assessment turrounding R37's pressure ed/soft and the margins were ressment further revealed no rere present. The assessment terventions of a pressure ess, turn and repositioning hours side to side, not to sit in eatment of saline soaked ng) and cover with ABD (thick still a pressure ulcer site. The ed a wound vac was to be give week following a diverting the bowel to an opening in the	F 31	4			

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F 314	pressure ulcer had slough tissue, surro macerated. The as interventions of we	age 27 assessment revealed R37's 70% granulation and 30% bunding skin was reddish and sessment identified current t to dry kerlix, cover with ABD a wound vac that week.	F3	14			
	pressure ulcer mea had undermining of moderate amount of which had a strong revealed R37's pre granulation and 50' skin was macerate current intervention Monday, Wednesd	led R37's stage 4 sacral asured 7 cm x 6 cm x 4.2 cm, in the top edges, had a of serosanguineous drainage odor. The assessment ssure ulcer had 50%% slough tissue, surrounding d. The assessment identified as of a wound vac changed on ay, Friday, air mattress, side to d CWON or primary care monitor weekly.					
	pressure ulcer mea cm, had a large am drainage which had assessment reveal 50% slough and 50 were maceration. T current intervention redistribution mattree reposition program assessment lacked	ed R37's stage 4 sacral asured 6.3 cm x 7.1 cm x 3.6 nount of serosanguineous d a strong odor. The ed R37's pressure ulcer had 3% granulation tissue margins The assessment identified as of wound vac, pressure ess, specific turn and and heel boots. The d mention of R37's surrounding ndermining continued to be					
	pressure ulcer mea had a moderate an	ed R37's stage 4 sacral asured 7 cm x 7 cm x 5 cm, nount of serosanguineous dor. The assessment revealed					

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F 314	(did not identify the had undefined, mac maceration on the sassessment reveal from the transparer R37's skin. The assintervention of a woredistribution mattrespecific turn and repositioning devices lacked the presence R37's clinical record wound assessment pressure ulcer from of 4 months. Review of R37's cli 8/6/15, identified R3 area on the buttock denuded skin which the buttocks. The foscale (a scale used sore development be mobility, nutrition, sore placed R37 area on the buttock denuded skin which the buttocks. The foscale (a scale used sore development be mobility, nutrition, sore placed R37 area on the buttocks. The foscale (a scale used sore development be mobility, nutrition, sore placed R37 area on the buttocks. The foscale (a scale used sore development be mobility, nutrition, sore placed R37's cli 12/24/15, identified pressure ulcer and developing pressure. Review of R37's tistest which measure and lying) dated 8/1 normal skin over boof lying. The assessing the properties of	er had 75% granulation tissue other 25% of tissue present,) cerated margins and had surrounding skin. The ed two areas of maceration at dressing adhesive pulling on sessment identified current bund vac, pressure ess, wheel chair cushion, positioning program, heel boots. The assessment e of undermining. Id lacked documentation of as completed of R37's as 8/19/15, to 12/24/15, a total mical health status form dated as and an area of chaffed, a measured 10 cm x 15 cm on orm identified R37's Braden to predict risk for pressure based on moisture, activity, ensory, friction and shear,) at high risk for pressure ulcers.	F3	314			

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F 314	R37 was able to tol redness or signs of revealed R37 had a was at severe risk to the Review of R37's photes from 10/22/1 following; -On 10/22/15, CWC three wounds which note identified R37 related to shear/prex 0.1 cm and was penter. The note identified R37 related to shear/prex 0.1 cm and was penter. The note identified atteral side of the lateral side of the lateral left heel, premeasured 1.5 cm and for some of load heels at all buttocks wound with large foam dressing and changeneeded. The note of as needed. -On 10/28/16, MD is large skin ulcer on -On 12/01/15, MD is wound was not assigned.	T dated 12/28/15, identified erate 1.5 hours of lying without breakdown. The assessment an order not to sit upright and for pressure ulcers. Pysician and CWON progress 5, to 1/16, revealed the ON note identified R37 had a required assessment. The had wound on the buttocks essure, measured 6 cm x 9 cm bink with a 0.5 cm dark area in entified R37 had a wound on the right heel, pressure easured 1 cm x 1 cm The ed R37 had a wound on the sure, non-blanchable, a 1 cm. The note directed staff times, and to cleanse the normal saline and apply a gwindowed with transparent are every 3 days and as directed to follow up with her mote identified R37 had a fairly the buttocks, decubitus ulcer. Inote revealed R37's sacral essed at the time of the visit.	F 31	4		
	open and looked lik	d and the wound was gaping se a stage 4 ulcer. The note O's plan was to have CWON				

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F 314	-On 12/16/15, MD is revealed R37 had a had increased in six been seen at the faulcer had deteriorate penetration of the sin the ulcer. The not significant drainage tissue. The note ide pressure ulcer with subcutaneous tissus surgically debrided R37's record revea from 12/30/15 to 1/colostomy in order treatment of the state of the state of the state of the state of the wound base and so from 7-12 o'clock, redrainage, no odor a from 7-12 o'clock. The wound edge of the wound edge of the wound edge of the wound edge at 4 o'clock. The pressure ulcer had with some adheren on 2/3/16, CWON areas of concern. The state of the state	al ulcer the following day. Inistory and physical note a sacral decubitus ulcer which are. The note revealed R37 had cility on 12/15/15, the sacral ded and there was complete kin and subcutaneous tissue the revealed there had been and evidence of necrotic entified R37 had a stage 4 complete penetration of the de and a plan to have the ulcer that day. Ided R37 had been hospitalized 6/16 for surgery for a diverting to place a would vac for tige 4 pressure ulcer. Inote identified R37's sacral disured 9 cm x 9 cm x 4 cm, and 11 o'clock of 3 cm. The note ssure ulcer had 75% red ome slough with a black area moderate amount of serous and had a 1 cm area of black at 11 o'clock. Note identified R37's sacral disured 8 cm x 7 cm x 5 cm dry necrotic area of the wound the note identified R37's 75% beefy red wound base	F 31	4		

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F 314	5 cm, had pink fast tissue enclosing at moderate serous d R37 had an area in shearing which me cm. The note revea on the left buttocks cm. The note revea on the left scapula and was described note further revealed the right scapula wand was also descrand had an intact be note identified R37 repositioning every for reddened areas. On 2/9/16, at 2:28 the medical doctor sacral pressure ulcostage 4 ulcer as the become suspicious expect facility staff ulcer weekly includ type. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side. The MD also facility staff to routi to side as the stated once the debrided it was det On 2/10/16, at 8:26 a stage 4 pressure stated she felt R37 started out as an u was able to be stage.	cia (a thin sheath of fibrous muscle or other organ,) rainage. The note identified the right gluteal crease from asured 1.4 cm x 3 cm x 0.1 aled R37 had a sheared area which measured 2.8 cm x 1 aled R37 had a pressure area which measured 4 cm x 10 cm as a blanchable redness. The ed R37 had a pressure area on hich measured 3 cm x 4 cm ribed as a blanchable redness blister 1 cm x 2 cm blister. The was to be assisted with hour by staff and to observe and to obtain a turning sheet. p.m. during a phone interview (MD), he stated he felt R37's see had likely always been a edges of the wound had and the monitor R37's pressure ing measurements and tissue stated he would expect the nely reposition R37 from side so stated R37's pressure ulcer a small pressure ulcer, though ard with its appearance. The pressure ulcer was surgically ermined to be a stage 4. So a.m. CWON verified R37 had ulcer to her sacrum. CWON 's pressure ulcer had likely instageable pressure ulcer and ged after the surgical DN stated R37 should be		4		

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		245540	B. WING		02	2/10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	repositioned every stated she had recorepositioned side to her body had begar stated R37 needed due to the blisters a ordered. On 2/10/16, at 9:01 interview the DON sprovide any comprefor R37 from 8/19/1 she were not sure stated she expected assessed weekly at stated she expected followed and recompliant to be followed to aid ulcer. On 2/10/16, at 3:13 hand written copies monitoring for 16 da 12/21/5 which the Arecreated from rand calendar and from plound in her office. re-created assessments, but so a wound evaluation measurements of the and notes on her calendar was required. A facility policy for put reatment was required.	In hour side to side. CWON ommended R37 be a side hourly once R37 sides of a to get red. CWON also a different type of lift sheet and abrasions which had been a.m. during a follow up stated they were unable to shensive wound assessments 5, to 12/24/15, and stated what happened. The DON d R37's pressure ulcer to be and monitored daily. The DON d R37's care plan to be amendations from the CWON d in healing R37's pressure p.m. the ADON provided of documentation of wound ates between 9/7/15 and ADON confirmed she had just dom notes on her personal post it notes which she had The ADON stated the ments were not complete the had written information on flow sheet for the dates and me wound from the post notes	F3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245540	B. WING			02/	10/2016
	PROVIDER OR SUPPLIER	NNING		9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MARSHALL AVENUE, PO BOX 57 IENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Pathway, which is a	ge 33 a pathway for investigation of or residents in long term care	F3	314			
F 329 SS=D	nutritional services, the dietitian would be monitoring and doc of nutritional needs pressure ulcer. 483.25(I) DRUG RE	y policy titled Pressure ulcers, reviewed 12/16/15, revealed be responsible for longing umentation of resident status with the presence of a EGIMEN IS FREE FROM RUGS	F3	329			3/21/16
	unnecessary drugs drug when used in a duplicate therapy); without adequate m indications for its us adverse consequen	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or conitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any e reasons above.					
	resident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and residen drugs receive gradubehavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug by to treat a specific condition documented in the clinical that who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245540	B. WING		02/	10/2016
	PROVIDER OR SUPPLIER	ENNING	9	STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	by: Based on observat review, the facility for effectiveness of an medication for 1 of obsessive compuls Findings include: R30's quarterly Min 1/18/16, identified Finance had no behaviors, for during the assessm R30's current care care which included care, and physical for address the use of compulisive disorded beahviors. R30's current medic physician 1/14/16, if 20 milligrams (mg) OCD (obsessive compuliary of R30's ph revealed R30 had be daily for OCD/anxie worms and obsessifications.	NT is not met as evidenced ion, interview, and document ailed monitor the ongoing antidepressant (Celexa) 5 residents (R30) utilized for ive disorder. imum Data Set (MDS) dated R30 was cognitively intact and nallucinations or delusions ient period. plan revised 5/16, directed disciplated and monitoring, however, did not Celexa related to obsessive er and monitoring of those cation orders signed by the dentified R30 received Celexa daily for the diagnoses of impulsive disorder)/anxiety /18/15. ysican note dated 11/3/15, been started on Celexa 10mg ety for delusions of greens ve thoughts of cleaning her led to occupy her thoughts and	F 329	F 329 It is the intent of Golden Living-He have all residents free of unnecest drugs. Resident #30 medication regimen been reviewed by the Consultant Pharmacist. Resident #30 care plan has been reviewed and revised as indicated regarding unnecessary medication Other residents reviewed by Pharmacist Consultant and none found to have unnecessary drugs. Monitoring to ensure compliance, DNS/designee will conduct random weekly audits of care plan, charts, eMAR for medication regimen. The results of the audits will be revat the QAPI meeting monthly.	has hacy e the and	
	revealed R30's dos	ycian note dated 11/17/15, e of Celexa had been				

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245540	B. WING		02/	10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	2/2/16 and review of Record (TAR) and I Record (MAR) January documentation of m Celexa related to b OCD. On 2/10/16, at 11:0 nursing (ADON) ve Celexa 20 mg daily behaviors with a sta ADON verified the address R30's use The ADON indicate OCD staff had been target behaviors an medications into the ADON identified the and document ever effects were preser progress note explain behavior and/or sid On 2/10/16, at 1:55 (DON) indicated R3 included the use of and interventions. To documentation sho monitoring of side of the control	nical record, 11/19/15 through of the Treatment Administration Medication Administration Jury and February, lacked nonitoring of the effect of Juris and the assistant director of Trified R30 currently received for the diagnosis of OCD and the diagnosis of OCD behaviors. It is a current care plan did not of Celexa for OCD behaviors. It is a current care plan did not of Celexa for OCD behaviors of the end and the TAR. The end was an another the end the the director of the end and if so, would write a saining the specifics of the effects. In the director of nursing B0's care plan should have Celexa, with target behaviors the DON verified and have been completed for effects.	F 32			
F 371 SS=E	483.35(i) FOOD PF	ity policy was not provided. ROCURE, /SERVE - SANITARY	F 37	1		3/21/16
	The facility must -					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245540	B. WING		02/1	0/2016
	PROVIDER OR SUPPLIER	ENNING	STREET ADDRESS, CITY, STATE, ZIP COD 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	considered satisfact authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food	F 371			
	by: Based on observareview, the facility fitems in the kitcher resident's refrigerar room were sealed had the potential to resided in the facility findings Include: On 2/7/16, at 9:08 revealed the middle cheddar cheese in around the packag package), and the was opened. Cook cheese was not sedate on the packag should be placed in on it, and it should On 2/7/16, at 1:50 north dining room of zip lock bag with on a circular black spoapproximately 0.25	a.m. the tour of the kitchen e refrigerator had a package of it with masking tape loosely e opening (but not sealing the cheese was not dated when it (C-A) verified the package of aled, and there was no open je. C-A stated the cheese in a plastic container with a lid be dated. p.m. the refrigerator in the contained a pealed orange in a ne section of 2 slices that had		F 371 It is the intent of Golden Living-Hen ensure residents are served food the been stored, prepared, and served sanitary manner. The refrigerator and freezer have be cleaned. Items in the refrigerator a freezer are dated and stored per postaff has been educated on cleanin storing, and dating food stored in the refrigerator/freezer. Monitoring to ensure compliance, the ED/designee will conduct random waudits of the refrigerator/freezer. The results of the audits will be reviat the monthly QAPI meeting.	een nd olicy.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY MPLETED
		245540	B. WING _		02	/10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP COD 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 371	approximately 0.5 of then 0.5 cm and the There was a reside it was not dated. The brown pie box with last initial on it. The 12/28/15. The pie is addition, there was been opened but he 1/6/16. At 2:10 p.m. stated the refrigeral used for the reside stated the oranges belonged to a reside stated the oranges belonged to a reside in the facility. RN-A a use by date of 12 been thrown away, practice was for hocheck the refrigerator expired they would housekeeping or about the food or if refrigerator they would housekeeping or about the food or if refrigerator they would housekeeping or about the food or if refrigerator they would housekeeping or about the food or if refrigerator dail items were availabed dining room and well on 2/9/16, at 3:15 the expired blueber	ircular areas on it; one area cm in size, one slightly smaller er 3rd area was pinpoint in size. Int's first name on the bag, but he refrigerator also contained a a resident's first name and a use date on the box was box contained 4 slices of pie. In a quart of eggnog that had not ad an expiration date of a registered nurse (RN-A) tor in the north dining room is not and their families. RN-A had mold on them and lent that was no longer residing a verified the blueberry pie had a registered nurse to tor daily and if the food is old all throw it away. RN-A stated maintenance have concerns they find outdated food in the bould throw it away and would stated they should be checking y and confirmed the food le for the residents in the north ere outdated. p.m. the dietitian (D)-D stated try pie, oranges with the dark		71		
	D-D verified the foother and the mold stated the dining defor outdated food a had not been done be labeling and dat	findings were not acceptable. od should have open dates on y oranges discarded. D-D epartment was to check daily and open dates on food, and it daily. D-D stated they should ing food items and checking oiled or has not expired daily.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	` '	E SURVEY IPLETED
		245540	B. WING _		02/	10/2016
	PROVIDER OR SUPPLIER	NNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428 SS=D	dates, labels and oppackage. The daily the a.m. and p.m. of food items. Review of the facilit from 1/4/16, to 1/31 had not checked for 27 days and the p.m. outdated food items the February cleani 2/9/16, identified the for outdated items 3 cook had not check. The facility policy tit Foods reviewed 2/1 all items daily for exand discard all outd 483.60(c) DRUG RI IRREGULAR, ACT. The drug regimen or reviewed at least or pharmacist. The pharmacist muthe attending physicials and part of the control of the contro	s should check for expiration cen dates on the food cleaning schedule indicated ook was to remove outdated y January cleaning schedule /16, identified the a.m. cook outdated food items 16 out of a. cook had not checked for a 8 out of 27 days. Review of an schedule from 2/1/16, to be a.m. cook had not checked out of 9 days and the p.m. and 1 out of 9 days. led Storage of Refrigerated 2/15, had indicated to monitor appriation dates or use by dates ated items daily. EGIMEN REVIEW, REPORT	F 42			3/21/16
	by:	NT is not met as evidenced and document review, the		F 428		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION		E SURVEY PLETED
		245540	B. WING		02/	10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	facility consulting pirregularity for 1 of ongoing monitoring antidepressant (Cetreat obsessive confindings include: R30's quarterly Min 1/18/16, identified In had no behaviors, Induring the assessive care which included care, and physical address the use of compulsive disorded behaviors. R30's current medial physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's physician 1/14/16, 20 milligrams (mg) OCD (obsessive consulting of R30's observed of R30's dose increased to 20 mg and hallucinations.	harmacist failed to identify the 1 residents (R30) who lacked of the effectiveness of an elexa) medication ordered to impulsive disorder. Immum Data Set (MDS) dated R30 was cognitively intact and hallucinations or delusions nent period. In plan revised 5/16, directed disabetes, activities, oral functioning, however, did not Celexa related to obsessive er and monitoring of those cation orders signed by the identified R30 received Celexa daily for the diagnoses of impulsive disorder)/anxiety	F 428	It is the intent of Golden Living-He ensure medication regimens are monthly for all residents. Resident #30 medication regimer been reviewed by the Consultant Pharmacist. Resident #30 care plan has been reviewed and revised as indicated regarding psychological diagnosis medications. Resident care plans have been reand revised as indicated for resid psychological diagnosis including residents with anti-depressant us Staff has been educated on upda plans with psychological diagnosi also educated on documenting be no change, or adverse side effect medication. Other residents identified as havinew psychotropic medication will care plans updated and documen regarding benefits, no change, or side effects. Pharmacy consultant will conduct audits of all resident charts. Beha health meeting with IDT will audit charts each week for documentat regarding benefits, no change, or effects of medications as well as trials. The results will be reviewed at Queeting monthly.	reviewed has has dents with es and eviewed ents with es. Staff enefits, s of this ing a have tation adverse monthly avioral random ion adverse reduction	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		245540	B. WING _		02/	10/2016	
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 428	Record (TAR) and Record (MAR) Jand documentation of n Celexa related to b OCD. Review of R30's pr 2/10/16 revealed th -12/8/15, resident p dose increased to 2 anxiety, appears to monitor. -1/15/16, no recom On 2/10/16, at 11:0 nursing (ADON) ve Celexa 20 mg daily behaviors with a sta ADON verified the address R30's use The ADON indicate OCD staff had beet target behaviors an medications into the ADON identified the and document ever effects were preser progress note explain behavior and/or sid On 2/10/16, at 1:55 (DON) indicated R3 included the use of and interventions.	of the Treatment Administration Medication Administration Medication Administration wary and February, lacked nonitoring of the effect of behaviors for the diagnosis of ogress notes from 11/16/15 to be following pharmacy notes: olaced on citalopram (Celexa), 20 mg 11/15 to help manage tolerate. Will continue to mendations 8 a.m. the assistant director of rified R30 currently received for the diagnosis of OCD art date of 11/18/15. The current care plan did not of Celexa for OCD behaviors of with orders of Celexa for nexpected to enter specific ad side effects of the enurses would then review by shift if the behaviors or side at and if so, would write a maining the specifics of the effects. 6 p.m. the director of nursing 30's care plan should have Celexa, with target behaviors The DON verified uld have been completed for	F 42	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245540	B. WING		02/	10/2016	
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		_D BE	(X5) COMPLETION DATE	
F 428	consulting pharmad was left. No return immediately after s	p.m. a call was placed to the cist for interview and message call was received during or urvey.	F 4	128			
F 441 SS=D	483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and control to help prevent the of disease and infection Control The facility must estable Program under which (1) Investigates, coin the facility; (2) Decides what preshould be applied to	l Program tablish an Infection Control	F 4	 41		3/21/16	
	determines that a reprevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di	ead of Infection ion Control Program esident needs isolation to of infection, the facility must					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245540	B. WING		02/1	0/2016	
	PROVIDER OR SUPPLIER	ENNING	g	STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	transport linens so infection.	ndle, store, process and as to prevent the spread of	F 441				
	by: Based on observareview, the facility from the container of glucose arried the container of open areas on all from the side of the carried the container of	tion, interview, and document ailed to ensure a multi- use as maintained in a sanitary he potential to effect 2 of 2 o		F 441 It is the intent of Golden Living-Henensure resident safety by infection measures. Residents #11 and #30 are receiving glucometer checks in a sanitary matchecks reviewed and are receiving checks in a sanitary manner. Licensed staff has been educated oproviding glucometer checks in a smanner. Monitoring to ensure compliance, DNS/designee will conduct random weekly audits of glucometer checks. The results of the audits will be reviat QAPI meeting monthly.	control ig anner. er on anitary		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED	
		245540	B. WING		02	/10/2016	
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE 907 MARSHALL AVENUE, PO HENNING, MN 56551	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	disposed of the use strip into a sharps of glucometer with a surveyor. On 2/07/16, at 12:2 had attempted to plucometer of the medication of the containers onto understand the bottom of the containers onto understand without sanitizing it container should hat towel on the over-thave been placed of further indicated the sanitized with a gerplacing it onto the treturning it to the discontaminated where resident's over-the-and agreed the mubeen sanitized beformedication cart. The expectation that the remain in the medication cart." The facility policy time the strip in the supply basket [medication] cart."	of the medication cart. RN-B and lancet and blood glucose container, and sanitized the germicidal bleach wipe. RN-A container into the top drawer art with other resident and was stopped by the container into the top cation cart without sanitizing container. RN-B identified it was a practice to place multi-use clean surfaces nor was it usual an item to the medication cart. RN-B indicated the multi-use are been placed onto a paper ne-bed table, and should not contop of the toilet tank. RN-B are bin should have been smicidal bleach wipe before op of the medication cart and rawer.	F4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING		MPLETED
		245540	B. WING		02	2/10/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP 907 MARSHALL AVENUE, PO BOX HENNING, MN 56551	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	would be cleaned a the CDC (Centers f recommendations. The CDC web page and Sterilization in identified "The ultim Recommendations Sterilization in Heal reduce rates of hea	the resident care equipment nd disinfected according to or Disease Control) e Guideline for Disinfection Healthcare Facilities, 2008,	F 4	141		

F5540025

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING 01 - MAIN BUILDING 01 245540 B. WING 02/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 **GOLDEN LIVINGCENTER - HENNING** HENNING, MN 56551 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 000 INITIAL COMMENTS K 000 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 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. At the time of this survey, Golden Livingcenter - Henning 01 Main Building 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 Or by e-mail to:

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

TITLE

(X6) DATE

Electronically Signed

03/10/2016

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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - Main Building 01		TE SURVEY MPLETED
		245540	B, WING_		02	/09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HENNING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FILLI				STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	OULD BE	(X5) COMPLETION DATE
K 000	Continued From pa Marian.Whitney@s or Angela.Kappenma	tate.mn.us	K 00	0		
	DEFICIENCY MUS FOLLOWING INFO	ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done				
		oposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency				
	building with out a constructed at 3 di building was const determined to be constructed and Type was constructed to	er - Henning is a 1-story basement. The building was fferent times. The original ructed in 1961 and was f Type II (111) construction. In as constructed to the north of g, is 1-story, without a e II (111). In 1988, an addition the south that was determined 0) construction which is not e original building.		Þ		
	automatic fire sprir accordance with N Installation of Auto edition. The facility smoke detection in open to the corrido automatic fire depa	tected throughout by an alkler system installed in FPA 13 The Standard for the matic Sprinkler Systems 1999 has a fire alarm system with the corridors and spaces rs that is monitored for artment notification installed in FPA 72 "The National Fire	,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245540 B, WING 02/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 **GOLDEN LIVINGCENTER - HENNING** HENNING, MN 56551 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 | Continued From page 2 K 000 Alarm Code" 1999 edition. The facility has a capacity of 42 beds and had a census of 23 at time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET K 017 NFPA 101 LIFE SAFETY CODE STANDARD K 017 2/23/16 SS=D Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the Insulate penetrations with fiberglass and facility failed to provide smoke resistant corridor seal louvers closed with fire Barrier walls that meet the requirements of NFPA 101 sealant; project to be completed by (00), sections 19.3.6.2.2 and 19.3.6.4. This Maintenance Dir. deficient practice could affect any residents using Completion Date: 2/23/2016 the dining room (a separate smoke compartment) and an undetermined amount of staff and visitors. Findings include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245540	B, WING		02/0	09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HENNING		9	TREET ADDRESS, CITY, STATE, ZIP CODE 107 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 017	Continued From pa	age 3	K 017			
K 050	on 02/9/2016 obsellocations in the low the location of the r These findings wer Maintenance Mana	between 8:30 am to 12:00 pm rvations revealed louvers at 3 er level corridor walls within maintenance office entrance. The observed by the facility ager. JEFTY CODE STANDARD	K 050			2/10/16
SS=D	Fire drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are quality where drills are consisted of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Based on review of interview,, it was detected to conduct fire drills LSC (00) Section 1 could affect how stimulations.	ne transmission of a fire alarm on of emergency fire Is are held at unexpected g conditions, at least quarterly staff is familiar with procedures Irills are part of established ility for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and nnouncement may be used	K 030	Follow NFPA requirements for Conducting Fire Drills. Begin using form that also requires signature of Executive Director. Completion Date: 2/10/2016		2, 10, 10
	Findings include: On the facility tour on 02/9/2016 docu fire drill for Novemb	between 8:30 am to 12:00 pm mentation review revealed the per of 2015 was missed. cice was verified by the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G 01 - Main Building 01		E SURVEY IPLETED
		245540	B. WING		02	09/2016
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 052 SS=F	A fire alarm syster be, tested, and ma NFPA 70 National National Fire Alarr available. The sysmaintenance and applicable require 9.6.1.4, 9.6.1.7, This STANDARD Based on observe revealed that the fire alarm system requirements of 2 19.3.4.1 and 9.6, 8 Sections 7.1. This adversely affect the system, and could and emergency as negatively affecting the system of the	m required for life safety shall aintained in accordance with Electric Code and NFPA 72 m Code and records kept readily tem shall have an approved testing program complying with ment of NFPA 70 and 72. is not met as evidenced by: ation and staff interview, it was facility had failed to maintain the in accordance with the 000 NFPA 101, Sections as well as 1999 NFPA 72, is deficient condition could be functioning of the fire alarm a delay the timely notification coins for the facility thus g all 23 residents and an ount of staff and visitors.	K 05	Summit to conduct sensitivity tertest will now be conducted annual documented in the Life Safety Bi Maintenance Dir. to monitor that completed annually. Completion Date: 2/11/2016	ally and nder.	2/11/16
K 062 SS=F	on 02/9/2016 doci there was no reco smoke alarms. This deficient prac Maintenance Man NFPA 101 LIFE S. Required automat continuously main condition and are periodically. 19.9.7.5	r between 8:30 am to 12:00 pm umentation review revealed that and of sensitivity tests of the edice was verified by the ager AFETY CODE STANDARD tic sprinkler systems are stained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by:	K 06	2		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY PLETED
		245540	B. WING		02/	09/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZI 907 MARSHALL AVENUE, PO BO HENNING, MN 56551	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 062	with staff, the facilit and maintain the ar accordance with NI Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire I deficient practice d sprinkler system is fully operational in negatively affect all	age 5 Intation review and interview by has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), d 4.6.12, NFPA 13 Installation ins (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could in 23 residents and an ount of staff and visitors.	KO	Follow NFPA requiremer fire sprinkler flow test. Lift to reflect documentation. computerized maintenan generate a work order que Maintenance Dir. to monis completed regularly. Completion Date: 2/10/2	e Safety Binder Added to the ce system to uarterly. itor to ensure test	
	on 02/9/2016 documented the last sprinkler flow. This deficient pract Maintenance Management of the control of	•				2/04/40
K 070 ; SS=D ;	Portable space hear prohibited in all hear it shall be permitted staff and employee elements of such didgrees F (100 deg 18.7.8, 19.7.8	ating devices shall be alth care occupancies. Except d to be used in non-sleeping areas where the heating levices do not exceed 212 grees C).	KO	70		3/21/16
	Based on obervation revealed that the farequirements for possible as per 2000 NFPA deficient practice of 13 resident rooms.	on and staff interview it was acility failed to meet the ortable space heating devices 101 section 19.7.8. This ould cause a fire and affect the in the North wing and an unt of staff and visitors.		Remove heater from res Educate staff that portab are not allowed in reside Dir. and ED to observe d environmental tours that heaters are not used in re Completion Date: 3/21/2	le space heaters nt rooms. Maint. uring regular portable space esident rooms.	

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			TE SURVEY MPLETED	
		245540	B. WING		02/0	9/2016	
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, 907 MARSHALL AVENUE, PO HENNING, MN 56551	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
K 070	on 02/9/2016 obse	age 6 between 8:30 am to 12:00 pm rvations revealed that a ater was being used in resident	ΚC	070			
K 072 SS=C	Maintenance Mana NFPA 101 LIFE SA Means of egress s free of all obstructi	AFETY CODE STANDARD hall be continuously maintained ons or impediments to full	Κ¢	072		2/10/16	
	No furnishings, decobstruct exits, according or visibility thereof 7.1.10. 18.2.1, 19.2 This STANDARD Based on observation means of egree obstructions or impute case of fire or accordance with N (2000 edition) Chadeficient practice of convenient and efficient according of the convenient and efficient exits according to the convenient according of the convenient according to the convenient ac	corations, or other emergency. Corations, or other objects shall ess thereto, egress there from, shall be in accordance with 2.1 is not met as evidenced by: It is not met as evidenced by		Maint. Dir. to remove thardware colliding and door will open with out other doors for this pothardware colliding. Completion Date: 2/10	verify entrance obstruction. Audit tential and remove		
	on 02/9/2016 obseresident rooms 17, and the main room mounted on the top both are opened to and not allow the expense of the control of the c	between 8:30 am to 12:00 pm ervations revealed that in , 5, and 7 the bathroom door a door, due to hardware ps of each door, collide when o a 45 degree and would bind entrance door to fully open.			a).		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00799

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245540	B. WING			02/	09/2016
	PROVIDER OR SUPPLIER	ENNING		9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MARSHALL AVENUE, PO BOX 57 IENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 130 SS=D	This STANDARD is Based on observative revealed that the farequirements of NF and S&C 14-46-LS tap strips. This deficient of visitors in case of visitors in case of the 23 residents of visitors in case of the facility tour on 02/9/2016 observesident room 34 the being charged through This deficient practive Maintenance Management of the serves of the s	CIENCY NOT ON 2786 is not met as evidenced by: tion and staff interview it was acility failed to meet the FPA 99 (99) section 7-5.1.2.6 C for the proper use of power cient practice could affect 10 and an undetermined amount of an electrical fire. between 8:30 am to 12:00 pm revations revealed that in the battery of a power chair was ugh the use of a power tap.	K	1130	The charger for the power chair by was removed from the power tap, be educated regarding what is allowed be plugged into a power tap. Maintand ED to observe during regular environmental tours that power tapused appropriately. Completion Date: 3/21/16	Staff to owed to t. Dir.	3/21/16
SS=C	under load for 30 n in accordance with 3-4.4.1 and 8-4.2 (1110) This STANDARD is Based on review of facility failed to main accordance with - 1999 edition and section 3-4.1.1.2. Taffect the safety of	ted weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by: of records and interview, the intain the emergency generator the requirements of NFPA 110 NFPA 99 - 1999 edition, This deficient practice could all 23 residents and an unt of staff and visitors.			Maint. Dir. to add a column to the generator test form to log the gene cool down. Completion Date: 2/9/2016		

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			PLETED
	245540	B. WING		02/0	9/2016
	ENNING		907 MARSHALL AVENUE, PO BOX 57		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	ge 8	K 144			
on 02/9/2016 docui	mentation review revealed that				
Maintenance Mana	ger	K 147			3/21/16
accordance with Na (NFPA 99) 18.9.1, This STANDARD is Based on observation MDH surveryor facility failed to mais wiring per NFPA 10 70. This deficient presidents and an unand visitors. Findings include: On the facility tour on 02/9/2016 observer.	ational Electrical Code. 9-1.2 19.9.1 s not met as evidenced by: tions and an email recieved by s it was revealed that the ntain the facilitys electrical 1 (99) section 9.1.2 and NFPA ractice could affet all 23 ndetermined amount of staff between 8:30 am to 12:00 pm reations and through an email		resident rooms for any needing rep Staff to be educated that taping of electrical outlet to hold in place in n allowed. Maint. Dir. to continue inspection verifying all outlets comp using the computerized preventativ	lacing. ot oly e	
electric outlet was was taped to hold is used to compensationse fit.	worn to a point that the TV plug t in place and the power tap te the worn outlet also had a				
Maintenance Mana NFPA 101 LIFE SA Where a required a out of service for m period, the authorit	ger FETY CODE STANDARD automatic sprinkler system is ore than 4 hours in a 24-hour y having jurisdiction is notified,	K 154			2/10/16
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa On the facility tour l on 02/9/2016 docur the generator cool of This deficient pract Maintenance Mana NFPA 101 LIFE SA Electrical wiring and accordance with Na (NFPA 99) 18,9.1, This STANDARD i Based on observat the MDH surveryor facility failed to mai wiring per NFPA 10 70. This deficient p residents and an ur and visitors. Findings include: On the facility tour l on 02/9/2016 obser from the MDH surv electric outlet was v was taped to hold if used to compensat loose fit. This deficient pract Maintenance Mana NFPA 101 LIFE SA Where a required a out of service for m period, the authority	PROVIDER OR SUPPLIER I LIVINGCENTER - HENNING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 documentation review revealed that the generator cool down was not being logged. This deficient practice was verified by the Maintenance Manager NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and an email recieved by the MDH surveryors it was revealed that the facility failed to maintain the facilitys electrical wiring per NFPA 101 (99) section 9.1.2 and NFPA 70. This deficient practice could affet all 23 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations and through an email from the MDH surveyors, it was revealed that an electric outlet was worn to a point that the TV plug was taped to hold it in place and the power tap used to compensate the worn outlet also had a	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 K 144 Continued From page 8 Continued	PROVIDER OR SUPPLIER 1 LIVINGCENTER - HENNING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY TIFLIL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 documentation review revealed that the generator cool down was not being logged. This deficient practice was verified by the Maintenance Manager NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and an email recieved by the MIDH surveryors it was revealed that the facility failed to maintain the facility selectrical wiring per NFPA 101 (199) section 9:1.2 and NFPA 70. This deficient practice could affet all 23 residents and an undetermined amount of staff and visitors. On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations and through an email from the MDH surveyors; it was revealed that an electric outlet was worn to a point that the TV plugwas taped to hold it in place and the power tap used to compensate the worn outlet also had a loose fit. This deficient practice was verified by the Maintenance Manager NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified,	TO THE CORRECTION 245540 245644 24560 245644 2456651 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246600 246

Facility ID: 00799

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G 01 - Main Building 01		E SURVEY IPLETED
		245540	B, WING _		02	/09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 154	unprotected by the system has been in This STANDARD Based on a record facility has failed to acceptable written be followed in the sprinkler system h for four or more holdeficient practice of for early response would affect the sa	age 9 rovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 is not met as evidenced by: direview and staff interview, the provide a complete and policy containing procedures to event that the automatic fire as to be placed out-of-service ours in a 24 hour period. This could affect the facility's ability and notification of a fire and afety of all 23 residents and an ount of visitors and staff.	K 154	Maint. Dir. to modify current meet expectations of a sepa policy. Print and insert in Life Binder. Completion Date: 2/10 /2016	rate proper e Safety	
K 155 SS=D	on 02/9/2016 revier revealed there was Sprinkler Out of Search Maintenance Mana NFPA 101 LIFE Search Where a required service for more than the authority havin building is evacual provided for all par shutdown until the	tice was verified by the ager. AFETY CODE STANDARD fire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been	K 15	5		2/10/16
	Based on a record facility has failed to acceptable written be followed in the	is not met as evidenced by: d review and staff interview, the p provide a complete and policy containing procedures to event that the automatic fire to be placed out-of-service for		Maint. Dir. to modify current meet expectations of a sepa policy. Print and insert in Lift Binder. Completion Date: 2/10/2016	rate proper e Safety	

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

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245540	B. WING		02/0	9/2016
	PROVIDER OR SUPPLIER	ENNING		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 155	(00) section 19.7. Taffect the facility's a notification of a fire all 23 residents, vis Findings include: On the facility tour to 002/9/2016 review revealed there was Alarm System Out	in a 24 hour period. NFPA 101 This deficient practice could ability for early response and and would affect the safety of itors and staff. Detween 8:30 am to 12:00 pm w of the documentation not a proper policy for the Fire of Service.	K 1	55		
			55			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00799



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically deliverred March 1, 2016

Ms. Joan Gedde, Administrator Golden LivingCenter - Henning 907 Marshall Avenue, PO Box 57 Henning, Minnesota 56551

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5540026

Dear Ms. Gedde:

The above facility was surveyed on February 7, 2016 through February 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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

Golden Livingcenter - Henning March 1, 2016 Page 2

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Gail Anderson at (218) 332-8140 or email: gail.anderson@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

PRINTED: 03/24/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00799 02/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 **GOLDEN LIVINGCENTER - HENNING** HENNING, MN 56551 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

Minnesota Department of Health

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

notice of assessment for non-compliance.

The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf

obul.htm The State licensing orders are delineated on the Minnesota Department of

INITIAL COMMENTS:

Electronically Signed 03/10/16

TITLE

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Health orders being Although no plan of State Statutes/Rule "corrected" in the bindicate in the elect under the heading orders will be corresubmitting to the M Health. Minnesota Department the State Licensing federal software. To assigned to Minnes Nursing Homes. The assigned tag in column entitled "ID statute/rule out of commany Statement and replaces the "To correction order. The findings which are in after the statement evidence by." Followare the Suggested Time period for Complex Plans of Control of the State of Control of the State of The	g submitted electronically. It correction is necessary for es, please enter the word ox available for text. Then ronic State licensure process, completion date, the date your cted prior to electronically innesota Department of The ent of Health is documenting and correction Orders using an umbers have been entered at a state statutes/rules for The ent of Deficiencies is listed in the ent of Deficiencies column to Comply portion of the ent of Deficiencies the notation of the state statute in violation of the state statute in violation of the state statute in the surveyors findings the surveyors findings method of Correction and crection. The HEADING OF THE	2 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	10/2016
	PROVIDER OR SUPPLIER	NNING 907 MARS		STATE, ZIP CODE NUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 2	2 302			
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED		2 302			3/21/16
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144	ING:				
	Alzheimer's disease or related of segregated or gene care staff	ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia				
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, th trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	by: Based on interview facility failed to ensi information regarding dementia training, in training program, the	and document review, the ure consumers were provided ng Alzheimer's disease and ncluding a description of the e categories of employees acy of training and the basic		Corrected		

Minnesota Department of Health

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		02/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(i	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	electronic form. In a	ne training in a written or addition the facility could not tion of Alzheimer's education lity staff.				
	Findings include:					
	information regarding	was found to include ng staff training of Alzheimer's ntia as required, including admission packet.				
	director of nursing (to locate Alzheimer who attended the tr facility was to provide required information	on 2/10/16, at 4:30 p.m., the (DON) verified she was unable 's education, training dates, raining and the information the de to consumers with the n regarding Alzheimer's ndicated she was not aware of				
	DON or designee of staff training to the consumer information	THOD OF CORRECTION: The ould add information regarding resident admission packet for on. The DON or designee and conduct audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 555	MN Rule 4658.0409 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555			3/21/16
	must develop a cor each resident within	elopment. A nursing home inprehensive plan of care for in seven days after the omprehensive resident				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	·NNIN(i	SHALL AVEI 3, MN 56551	NUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 555	assessment as deficomprehensive plate by an interdisciplina attending physician responsibility for the appropriate staff in the resident's needs practicable, with the the resident's legal representative. This MN Requirements assed on observation review, the facility for include appropriate hearing for 1 of 1 residenting. Findings include: R24's quarterly Min 11/18/15, identified impairment, ability the normally used with required speaker to distinctly, required for personal hygien Area Assessment (diagnoses which in accident, blindness hearing. R24's current care identified R24 had be communication due preferred to wear of directed staff to ensigned to the construction of the preferred to wear of directed staff to ensigned to the construction of the preferred to wear of directed staff to ensigned to the construction of the preferred to wear of directed staff to ensigned to the construction of the construction of the preferred to wear of directed staff to ensigned to the construction of t	ned in part 4658.0400. The nof care must be developed any team that includes the a registered nurse with a resident, and other disciplines as determined by so, and, to the extent a participation of the resident, guardian or chosen ent is not met as evidenced on, interview and document alled to develop a care plan to interventions to assist in assidents (R24) reviewed for immum Data Set (MDS) dated R24 had moderate cognitive or hear with hearing aid moderate difficulty, and increase volume and speak extensive assistance from staff e, and dressing. The Care CAA) dated 8/28/15, identified cluded cerebral vascular, depression, and hard of plan revised 1/28/16, blindness, impaired to impaired hearing, ally one hearing aid and sure hearing aid was in place	2 555	Corrected		
		wever, did not specify staff to to the ear with the hearing aid				

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATION	UPPLIER/CLIA ON NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		00799		B. WING			02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - HE	ENNING		SHALL AVEN i, MN 56551	IUE, PO BOX 57			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI Y MUST BE PRECED SC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	BE	(X5) COMPLETE DATE
2 555	Continued From pa	ige 5		2 555				
	in place.							
	During the initial int R24 was asked if s decisions about you treatments? R24 st of anything. I think don't want me to kn about."	taff included hin ur medicine, the tated,"They don' they whisper so	m/her in erapy, or other 't tell me much metimes, they					
	During the evening p.m. to 6:12 p.m. R hearing aid in the le (NA)-A was seated handed R24 an eat where R24's food it R24 did not voice a did not make an eff "Is your hearing aid R24 a bowl of soup it up to his/her mouth NA-cueing R24 to eat, anot have the hearing	24 was observed at the ear. Nursing on the right side on the right side on the right side of the ear. Nursing are sponse to Nursing?" and on R24 accepted of the ear of the ear.	ed to have a assistant e of R24. NA-A explained ed on the table. A-A, and R24 NA-A stated then handed the bowl, held d soup into d repeatedly ear that did					
	On 2/09/16, at 8:4 (LPN)-B approache white paper cup. LF ear and placed the LPN-B asked R24 right ear if somethin R24 did not respon was asked and with staff appeared to be his/her head from swith a stern "no."	ed R24 with med PN-B spoke in to medicine cup in while speaking ng more to drink d the first time to repeated ques ecome agitated side to side and	dications in a o R24's right in R24's hand. in to his/her is was needed. The question stioning from a R24 shook responded					
	On 2/09/16, at 2:54 walk down the from room for coffee and	R24's room to	the dining					

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	·NNIN(i	SHALL AVEN 3, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 555	R24's right side talk hearing aid. On 2/08/16, at 6:28 wore one hearing a	sing to the ear without the 3 p.m. NA-A verified R24 only id, but was not aware which earing aid in. NA-A agreed	2 555			
	R24 would be able with the hearing aid utilized R24's right attempt to commun confirmed R24's lef	to hear better out of the ear I. NA-A confirmed he/she had ear, without the hearing aide to icate with R24. NA-A t ear had not been used to icate and stated "I didn't think				
	although R24 did ha ears, R24 was able	45 a.m. NA-B indicated ave a hearing aid for both to hear better with the left ear wear the hearing aid only in				
	wore only one hear adequately if it was loudly. R24 stated "	2 a.m. R24 identified he/she ing aid and was able to hear quiet and the speaker spoke They should know I hear with aring aid. The other ear is no				
	(DON) verified she into the ear which F DON indicated R24 hearing aid and nee appropriately should	ne staff in order for staff to be				
	The requested facil planing was not pro	ity policy regarding care vided.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			7 501251110.			
		00799	B. WING		02/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HE	-NNIN(-	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ige 7	2 555			
	The director of nurs development and in procedures to ensu- plans. The director then monitor the ap to the policies and	THOD OF CORRECTION: sing or designee could implement policies and ure the development of care of nursing or designee could propriate staff for adherence procedures. R CORRECTION: Twenty one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/21/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and document ailed to implement care plan sitioning for 1 of 2 residents pressure ulcers.		Corrected		
	Findings include:					
	identified R37 had a care plan identified staff to turn and rep R37's care plan list pressure relieving r	are plan dated 8/24/15, a current pressure ulcer. R37's R37 required assistance of 2 position every 1-2 hours. ed various interventions of a mattress and to complete essments on R37's pressure				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HE	·NNING	SHALL AVEN 6, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
	3:56 p.m. to 6:26 p.	ontinuous observations from m., R37 was observed lying in e without being offered, or on during the entire				
	bed with an air alter	was lying on her right side in rating mattress in place. R37 ands, eyes were open and the				
	bed, had set her bo	remained on her right side in ok on the bed and closed her observed to offer assistance.				
	right side. The social to enter R37's room R37 opened her eye	remained lying in bed on her all worker (SW) was observed and spoke briefly with R37. es and nodded. The SW then closed her eyes and remained				
	right side, covers up assistant (NA)-A wa R37's room. NA-A o	remained lying in bed on her to mid torso. Nursing alked down the hallway, past did not offer R37 assistant with emained on her right side				
	into R37's room, as colostomy bag while side. RN-B adminis fluid flushes via gas hooked up R37's tu head of bed. RN-B	tered nurse (RN)-B walked sisted to empty R37's e R37 remained on her right tered R37's medications and stric tube (g-tube.) RN-B be feeding and raised R37's was not observed to offer R37 left R37's room at 5:44 p.m., er right side.				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPIDENTIFICATION			E CONSTRUCTION		E SURVEY PLETED
				7.1. 20.22.1.10.1			
		00799		B. WING		02/	10/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	ENNING		SHALL AVEN i, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 9		2 565			
	- At 6:20 p.m. R37 right side with eyes up to her torso. No assistance with rep - At 6:26 p.m. RN-E (DON) entered R37 lifted R37's body withe DON. R37 was side, facing RN-B. pad unattached, up to R37's buttocks woon and RN-B. R from the bottom of bottom of her thigh and top sheets were peeled the blue incountocks skin and put tissue from two 1 con the right edge of upper right thigh. Thareas were from account of the peeled the blue incountocks skin and put tissue from two 1 con the right edge of upper right thigh. Thareas were from account of the peeled the blue incount of the right edge of upper right thigh. Thareas were from account of the second of	remained lying in a closed and a blan staff was observed positioning. B and the director of the close and a lift sheet and a lift sheet and a sasisted to turn to R37 had a blue included her buttocks when she was turned 37's skin was damed the hair on her head as R37's pillow cas a laso damp/moist ontinent pad away bulled a layer of gram x 1 cm circular of R37's right buttook he DON stated shed the sive tape which is entire sacrum was dressing which held a canister which can be a can	ket covered d to offer of nursing d the DON R37 towards her left continent which stucked by the p/moist ad to the e, fitted, lift to The DON from R37's anulation open area's ks and e felt these was not as covered d a black in place. A rethe ed to a ollected e ulcer, or with linen the The DON is imprinted				
	blanchable redness buttocks, hip and the had a current stage indicated R37 was	nigh. The DON cone 4 sacral pressure on a every hour sid	nfirmed R37 ulcer and de to side				
	repositioning progra	am. The DON and	KN-R				

Minnesota Department of Health

STATE FORM 5899 5RL311 If continuation sheet 10 of 51

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551 (X4) ID PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 10 assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels. On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes. On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed on R37s right side.		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE 2 565 Continued From page 10 2 565 assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels. On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes. On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed			00799	B. WING		02/	10/2016
CALL DESCRIPTION SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY DEFICIENCY 2 565 Continued From page 10 assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels. On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes. On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed	NAME OF	PROVIDER OR SUPPLIER					
### PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	GOLDE	N LIVINGCENTER - HE	-NNING		JE, PO BOX 57		
assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels. On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes. On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI	HOULD BE	COMPLETE
On 2/8/16, at 7:10 p.m. nursing assistant (NA)-E stated she had last repositioned R37 around 3:30 p.m. NA-E stated she understood R37 was on a every 2 hour repositioning schedule and stated she was unaware R37 was supposed to be repositioned every hour. On 2/8/16, at 7:43 p.m. NA-A stated he had not assisted R37 to reposition since about 3:30 p.m.	2 565	assisted R37 to her pillows covered in a alternating pressure bilateral tan colored heels. On 2/8/16, at 6:36 prequired assistance side to side to prevent the DON confirme pressure ulcers. The lay on her back and stage 4 pressure ulstated she was unsure positioned as ord and ostomy nurse (she expected staff reposition side to siverified R37 had last p.m. The DON verifight side for a total on 2/8/16, at 6:53 prevent further skin about a week ago won R37's right side. On 2/8/16, at 7:10 pstated she had last p.m. NA-E stated she very 2 hour repositioned every On 2/8/16, at 7:43 personal stated she had last p.m. NA-E stated she very 2 hour repositioned every	r left side and positioned dry pillow cases. R37 had an emattress in place and had heel protectors on both. D.m. the DON stated R37 for repositioning every hour ent further skin breakdown. dr R37 was at high risk for the DON stated R37 was not to draw bedridden due to the cer on her sacrum. The DON ure why R37 was not ered by the certified wound CWON). The DON stated to assist R37 to turn and de every hour. The DON stated to assist R37 to turn and de every hour. The DON stated to assist R37 had remained on her of 2 hours and 56 minutes. D.m. the assistant director of ated the a CWON had directed de to side every hour to breakdown/pressure ulcers when abrasions were noticed. D.m. nursing assistant (NA)-E repositioned R37 around 3:30 he understood R37 was on a tioning schedule and stated R37 was supposed to be hour.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
	PROVIDER OR SUPPLIER	NNING 907 MAR		STATE, ZIP CODE IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	assist R37 with represidents had need R37 had not been residents had need R37 had not been residents, a total of Review of the facilit Status, Additional A Plan of Care (IPOC indicated an residencompleted. In addit were checked on the indicated the need section. SUGGESTED MET The director of nursidevelopment and in procedures to ensuring implemented. The could then monitor	ositioning because other	2 565			
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a n provides that: A. a resident wh	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home pres does not develop	2 900			3/21/16

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE COMP		SURVEY LETED
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 12	2 900			
	condition demonstr authenticates, that B. a resident w receives necessary	ess the individual's clinical ates, and a physician they were unavoidable; and the has pressure sores by treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility f assess and failed to of a worsening pres (R37) reviewed for the facility failed to interventions for 1 of for pressure ulcers resulted in actual h	ent is not met as evidenced on, interview and document ailed to comprehensively conduct ongoing monitoring soure ulcer for 1 of 2 residents pressure ulcers. In addition, implement repositioning of 2 residents (R37) reviewed This deficient practice arm for R37, who had a stage orsen to a stage 4 pressure		Corrected		
	Findings include:					
	(MDS) dated 1/25/1 cognitive impairment included: encephalor pressure ulcers. The totally dependent undaily living (ADL's.) stage 4 (full thicknessone, tendon or must be present on some Often includes undaily living (cm) long, 7.0 cm visions includes undaily living (cm) long, 7.0 cm visions includes undaily long, 7.0 cm visions includes includes undaily long, 7.0 cm visions includes includes included includes includes includes included includes inclu	arterly Minimum Data Set 16, identified R37 had severe nt and had diagnoses which opathy, dysphagia and le MDS identified R37 was pon staff for all activities of The MDS identified R37 had a less tissue loss with exposed lescle. Slough or eschar may le parts of the wound bed. lermining and tunneling) leth measured 8.0 centimeters wide and 4.2 cm deep. The let's stage 4 pressure ulcer had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HE	·NNING	SHALL AVEN G, MN 56551	UE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	worsened since the MDS listed pressure included: pressure pressure relieving of and repositioning processor of R37's addidentified R37 had and had diagnoses encephalopathy, dy The MDS identified staff for all ADL's. The MDS identified staff for all ADL's. The MDS identified staff for all ADL's. The modern of the presenting as a shared-pink wound been present as an intact pressure ulcer. The interventions included pressure relieving of R37's pressure relieving of Review of R37's pressure in the pressure responsibility and reposition of R37's caidentified R37 had a care plan identified staff to turn and repressure relieving modern of R37's care plan list pressure ration of R37's	e previous assessment. The e ulcer interventions which ulcer care, dressing changes, device for bed and a turning rogram. mission MDS dated 8/13/15, severe cognitive impairment which included: sphagia and pressure ulcers. R37 was totally dependent or the MDS identified R37 had a kness loss of dermis allow open ulcer with a d, without slough. May also to ropen/ruptured blister) MDS listed pressure ulcer ed: pressure ulcer care and a device for bed. essure ulcer Care Area dated 8/13/15, identified R37 sure ulcer. The CAA identified pressure ulcer development cal assistance with bed				
	3:56 p.m. to 6:26 p.	ontinuous observations from m., R37 was observed lying ir e without being offered, or				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
	PROVIDER OR SUPPLIER	NNING 907 MARS		STATE, ZIP CODE IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	assisted to reposition observation. - At 3:56 p.m. R37 is bed with an air alter had a book in her home lights were or at 4:15 p.m. R37 is bed, had set her bounded by bed, and set her bounded by bed	on during the entire was lying on her right side in rnating mattress in place. R37 ands, eyes were open and the n. remained on her right side in rok on the bed and closed her observed to offer assistance. remained lying in bed on her all worker (SW) was observed and spoke briefly with R37. Les and nodded. The SW then closed her eyes and remained alked down the hallway, past did not offer R37 assistant with remained on her right side tered nurse (RN)-B walked sisted to empty R37's Let R37 remained on her right tered R37's medications and stric tube (g-tube.) RN-B be feeding and raised R37's was not observed to offer R37 tering and raised R37's was not observed to offer R37 tering and raised R37's register.	2 900			
	right side with eyes	remained lying in bed on her closed and a blanket covered staff was observed to offer ositioning.				

IVIInneso	<u>ita Department of He</u>	<u>ealth</u>				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		00799	B. WING		02/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STDEET	ADDRESS, CITY, S	STATE ZID CODE	-	
INAIVIL OF I	THO VIDEN ON SOLT EIEN			IUE, PO BOX 57		
GOLDEN	I LIVINGCENTER - HE	-NNING	NG, MN 56551	NUE, PU BUX 57		
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
2 900	Continued From pa	ngo 15	2 900			
2 900	Continued From pa	ige 15	2 900			
	4					
		B and the director of nursing				
		7's room. RN-B and the DON ith a lift sheet and R37 towar				
		assisted to turn to her left	23			
		R37 had a blue incontinent				
		nder her buttocks which stuc	<			
		when she was turned by the				
		37's skin was damp/moist				
		the hair on her head to the				
		s. R37's pillow case, fitted, lif				
		e also damp/moist. The DON				
		ontinent pad away from R37'	S			
		oulled a layer of granulation	,			
		m x 1 cm circular open area' f R37's right buttocks and	5			
		the DON stated she felt these				
		the BON stated she left these				
		s entire sacrum was covered				
		dressing which held a black				
		onge (wound vac) in place. A				
		served from under the				
		ng and was attached to a				
	suction device with	a canister which collected				
		's stage 4 pressure ulcer.				
		k purple/ red in color with line	en			
		ire right side (from the				
		tom of her thigh.) The DON				
		's skin had creases imprinted	1			
		damp from sweat and had				
		s on her right side shoulder, nigh. The DON confirmed R3	87			
		e 4 sacral pressure ulcer and	,,,			
		on a every hour side to side				
		am. The DON and RN-B				
		r left side and positioned				
		dry pillow cases. R37 had an				
		e mattress in place and had				
		heel protectors on both				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			
		00799		B. WING		02/	10/2016
NAME OF PROVIDE	R OR SUPPLIER				STATE, ZIP CODE		
GOLDEN LIVING	GCENTER - H	ENNING		SHALL AVEN i, MN 56551	IUE, PO BOX 57		
	ACH DEFICIENC	ATEMENT OF DE Y MUST BE PREC LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 900 Conti	nued From pa	age 16		2 900			
On 2/ requir side to the Depress lay or stage stated repose and of shee erepose verified p.m. right so the Prepose further week right so was rewound had be on herepose stated 2 pressurgice ADON the stage sacru	B/16, at 6:36 ed assistance of side to previous confirme ure ulcers. The her back and 4 pressure ulses was unsitioned as ord stomy nurse expected staffition side to side R37 had lated for a total side for a total side. ADON stated if it in R37 side of assessment and ago when abside. ADON seponsible for a sacrum and it in a sacrum and	p.m. the DONe for reposition rent further sked R37 was an ed DON stated was bedriddered by the control of the present at ed R37 had a stage 4 present at ed R37 required R37 required R37 required R37 had been on the present at ed R37 had a stage 4 present at ed R37 required R37	oning every hour kin breakdown. It high risk for ad R37 was not to den due to the acrum. The DON as was not certified wound be DON stated at the dur. The DON sitioned at 3:30 remained on her and 56 minutes. It is the person who of the weekly DON stated R37 a turn and a turn				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLDE	NULWINGOENTED U	907 MARS	SHALL AVEN	IUE, PO BOX 57		
GOLDE	N LIVINGCENTER - HE	ENNING HENNING	, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 900	a wound vac could sacral pressure ulcer was unable to provi the electronic medic December 2015. All weekly wound asses 8/16/15 to 12/15 for worsened from a st stage 4 pressure ulcer and ADON present machine was obser R37's stage 4 sacra droul smelling. A from R37's sacrum R37 had a increase	be placed to R37's stage 4 er. ADON indicated R37 had assessments in August and ide any further assessments in cal record (EMR) until DON confirmed there were no essments in R37's EMR from or R37's pressure ulcer which age 2 pressure ulcer to a cer. o.m. nursing assistant (NA)-E repositioned R37 around 3:30 he understood R37 was on a tioning schedule and stated a37 was supposed to be hour. o.m. NA-A stated he had not rosition since about 3:30 p.m. as supposed to be repositioned a-A stated staff were unable to ositioning because other	2 900			

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - HE	-NNING-	SHALL AVEN 3, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	2 cm from the oper was present from a o'clock position of t felt R37 had been and had caused prox 1.0 cm of R37's s 12-1 o'clock position wound had tunnelir o'clock. CWON state pressure ulcer mean wide and was 3.5 chad superficial oper her right buttocks a diameter. She also staff after the trans wound vac had been caused the new op CWON stated R37 blisters, one on each to the lift sheet bein CWON stated R37 in early February and	necrotic tissue which extended hing of the sacral ulcer and a 9 o'clock position to the 11 he wound. CWON stated she laying on one side too long essure. CWON stated 0.5 cm facral bone was visible at the shear. CWON stated R37's sacral ng present from 9 o'clock to 3 ted R37's stage 4 sacral assured 5.5 cm long x 6 cm shear deep. CWON indicated R37 in areas from adhesive tape on and thigh both were 2 cm in stated she had re-educated parent dressings used with the en applied incorrectly and en areas on the buttocks. also had two 2 cm diameter ch shoulder from shearing dueing kept under R37. The 's shearing areas were noted and a different lift sheet had ad not arrived in facility at				
		eekly wound assessments 24/15, revealed the following:				
	the facility with a st buttocks. The asse 2 pressure ulcer me cm and had 100% assessment identifi pressure redistribut cream to the ulcer	ed R37 had been admitted to age 2 pressure ulcer on the ssment revealed R37's stage easured 2.1 cm x 2.2 cm x 0.1 epithelial tissue present. The ied current interventions of a tion mattress and barrier every shift.				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	. 6		A. BUILDING:				
		00799	B. WING		02/1	0/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	N LIVINGCENTER - HE	-NNING-	SHALL AVEN 3, MN 56551	IUE, PO BOX 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	 ige 19	2 900				
	ulcer measured 2.1 had 100% epithelia. The assessment id of a pressure redist cream and a turn a every 2 hours. -On 12/24/15, ident pressure ulcer. The was admitted with a become worse and surgical debrideme. The assessment reulcer measured 8.2 red with 75% granu granular form on ar of a wound) tissue, yellow, tan, gray, gr moist, can be soft, texture. Slough mathe wound or prese wound bed,)tissue of serosanguineou amounts of blood) or revealed the skin stundefined. The ass tunneling or odor widentified current in redistribution mattre program of every 2 a wheelchair and trikerlix (gauze packin absorbent dressing tape on R37's skin assessment reveale placed the following	cm x 2.1 cm x 0.1 cm and all (definition) tissue present. Identified current interventions tribution mattress, barrier and repositioning program of tified R37 had a stage 4 sacral exassessment revealed R37's a pressure ulcer which had required hospitalization for a set of the sacral pressure ulcer. It was allation (new vascular tissue in a ulcer or the healing surface 25% slough (non-viable reen or brown tissue; usually stringy and mucinous in y be adherent to the base of ent in clumps throughout the and had a moderate amount as (yellowish serum with small drainage. The assessment urrounding R37's pressure end/soft and the margins were essessment further revealed no rere present. The assessment terventions of a pressure ess, turn and repositioning hours side to side, not to sit in the eatment of saline soaked ang) and cover with ABD (thick and pressure ulcer site. The ed a wound vac was to be given to an opening in the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
			71. 501251110.				
		00799	B. WING		02/1	0/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDE	I LIVINGCENTER - HE	-NNIN(-	SHALL AVEN i, MN 56551	IUE, PO BOX 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	pressure ulcer meacm, had undermining wound from 1 o'closs moderate amount of and no odor. The appressure ulcer had slough tissue, surrounderated. The assinterventions of well and a plan to place. On 1/28/16, reveal pressure ulcer meansure ulcer meansure ulcer meansure ulcer meansure amount of which had a strong revealed R37's pregranulation and 50°s skin was macerated current intervention Monday, Wednesds side positioning and provider (PCP) to note that a large amount of the pressure ulcer meansure ulcer mean	d R37's stage 4 sacral asured 9.2 cm x 10 cm x 5.2 mg on the right side of the ck to 3 o'clock, had a of serosanguineous drainage ssessment revealed R37's 70% granulation and 30% bunding skin was reddish and sessment identified current at to dry kerlix, cover with ABD a wound vac that week. The R37's stage 4 sacral asured 7 cm x 6 cm x 4.2 cm, in the top edges, had a of serosanguineous drainage odor. The assessment sesure ulcer had 50% slough tissue, surrounding d. The assessment identified is of a wound vac changed on ay, Friday, air mattress, side to d CWON or primary care	2 900				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEI	N LIVINGCENTER - HE	-NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	-On 2/3/16, revealed pressure ulcer mean had a moderate and drainage with no on R37's pressure ulce (did not identify the had undefined, maceration on the sassessment reveal from the transparer R37's skin. The assintervention of a woredistribution mattrespecific turn and repositioning devices lacked the presence R37's clinical recommend assessment pressure ulcer from of 4 months. Review of R37's clinical recommend assessment pressure ulcer from of 4 months. Review of R37's clinical recommend assessment pressure ulcer from of 4 months. Review of R37's clinical recommend assessment pressure ulcer from of 4 months. Review of R37's clinical recommend assessment pressure ulcer from of 4 months.	d R37's stage 4 sacral issured 7 cm x 7 cm x 5 cm, fount of serosanguineous for. The assessment revealed for had 75% granulation tissue other 25% of tissue present, becrated margins and had surrounding skin. The fed two areas of maceration for dressing adhesive pulling on sessment identified current found vac, pressure fess, wheel chair cushion, positioning program, heel boots. The assessment fer of undermining. If alacked documentation of the scompleted of R37's for 8/19/15, to 12/24/15, a total form identified R37's for measured 10 cm x 15 cm on form identified R37's Braden for predict risk for pressure for predict risk for pressure for pressure for the predict risk for pressure for the predict risk for pressure for the pressure for the pressure for the pressure ulcers.	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(-i	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 22	2 900			
	of lying. The assess	ony prominences after 2 hours sment revealed R37 was at ping pressure ulcers.				
	R37 was able to tol redness or signs of	T dated 12/28/15, identified erate 1.5 hours of lying without breakdown. The assessment an order not to sit upright and for pressure ulcers.				
		ysician and CWON progress 5, to 1/16, revealed the				
	three wounds which note identified R37 related to shear/prex 0.1 cm and was possible. The note identified the lateral side of the non-blanchable, menote further identified lateral left heel, premeasured 1.5 cm x off load heels at all buttocks wound wit large foam dressing and change	ON note identified R37 had a required assessment. The had wound on the buttocks essure, measured 6 cm x 9 cm sink with a 0.5 cm dark area in entified R37 had a wound on the right heel, pressure easured 1 cm x 1 cm The ed R37 had a wound on the ssure, non-blanchable, 1 cm. The note directed staff times, and to cleanse h normal saline and apply a g windowed with transparent ge every 3 days and as lirected to follow up with her				
		note identified R37 had a fairly the buttocks, decubitus ulcer.				
		note revealed R37's sacral essed at the time of the visit.				
		note revealed R37's sacral				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNING-	IG, MN 56551	NUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	further revealed ME assess R37's sacra -On 12/16/15, MD is revealed R37 had a had increased in size been seen at the faulcer had deteriorate penetration of the sin the ulcer. The note idepressure ulcer with subcutaneous tissue. The note idepressure ulcer with subcutaneous tissue surgically debrided R37's record reveal from 12/30/15 to 1/c colostomy in order treatment of the star -On 1/8/16, CWON pressure ulcer mean had undermining at identified R37's prewound base and so from 7-12 o'clock, redrainage, no odor a of the wound edge -On 1/14/16, CWOI pressure ulcer mean with a 2 cm x 3 cm edge at 4 o'clock. The pressure ulcer had with some adherent with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had with some adherent results of the wound edge at 4 o'clock. The pressure ulcer had	te a stage 4 ulcer. The note D's plan was to have CWON al ulcer the following day. Inistory and physical note a sacral decubitus ulcer which ze. The note revealed R37 has actility on 12/15/15, the sacra ted and there was complete skin and subcutaneous tissue and evidence of necrotic entified R37 had a stage 4 complete penetration of the re and a plan to have the ulcer that day. Iled R37 had been hospitalize 6/16 for surgery for a diverting to place a would vac for age 4 pressure ulcer. Inote identified R37's sacral asured 9 cm x 9 cm x 4 cm, at 11 o'clock of 3 cm. The note ressure ulcer had 75% red ome slough with a black area moderate amount of serous and had a 1 cm area of black at 11 o'clock. N note identified R37's sacral asured 8 cm x 7 cm x 5 cm dry necrotic area of the wourfhe note identified R37's 75% beefy red wound base	d d			
		he note revealed R37's stage	;			

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00799		B. WING		02/10/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/1	0/2010
GOLDEN LIVINGCENTER - HENNING 907 MARS				IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	4 sacral pressure upon the left buttocks cm. The note reveal on the left scapula and was described note further revealed the right scapula which medical doctors acral pressure ulcustage 4 ulcer as the become suspicious expect facility staff ulcer weekly includ type. The MD also facility staff to routing to side. The MD also facility staff once the debrided it was determined to be stage 4 pressure stated she felt R37 started out as an unwas able to be stage.	lcer measured 7 cm x 7 cm x bia (a thin sheath of fibrous muscle or other organ,) rainage. The note identified the right gluteal crease from asured 1.4 cm x 3 cm x 0.1 aled R37 had a sheared area which measured 2.8 cm x 1 aled R37 had a pressure area which measured 4 cm x 10 cm as a blanchable redness. The ed R37 had a pressure area on hich measured 3 cm x 4 cm ribed as a blanchable redness lister 1 cm x 2 cm blister. The was to be assisted with hour by staff and to observe and to obtain a turning sheet. D.m. during a phone interview (MD), he stated he felt R37's er had likely always been a redges of the wound had a redges of the would to monitor R37's pressure ing measurements and tissue stated he would expect the nely reposition R37 from side to stated R37's pressure ulcer, small pressure ulcer, though ard with its appearance. The pressure ulcer was surgically ermined to be a stage 4. Ta.m. CWON verified R37 had ulcer to her sacrum. CWON is pressure ulcer and likely instageable R37 should be				

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GOLDEN	I LIVINGCENTER - HE	·NNING	SHALL AVEN , MN 56551	UE, PO BOX 57		
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2 900	repositioned every stated she had recorepositioned side to her body had begar stated R37 needed due to the blisters a ordered. On 2/10/16, at 9:01 interview the DON sprovide any comprefor R37 from 8/19/1 she were not sure stated she expected assessed weekly at stated she expected followed and recom to be followed to aid ulcer. On 2/10/16, at 3:13 hand written copies monitoring for 16 da 12/21/5 which the Arecreated from rand calendar and from pfound in her office. re-created assessments, but sa wound evaluation measurements of the and notes on her calendar was required. A facility policy for patreatment was required.	If hour side to side. CWON and a different type of lift sheet and abrasions which had been a.m. during a follow up stated they were unable to shensive wound assessments 5, to 12/24/15, and stated what happened. The DON d R37's pressure ulcer to be and monitored daily. The DON d R37's care plan to be amendations from the CWON d in healing R37's pressure. p.m. the ADON provided of documentation of wound a description of the personal and a documentation of wound a documentation of wound and a documentation of wound a	2 900			
	2012 (7/20/15), title	d Positioning Critical Element pathway for investigation of				

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	HENNING.					
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2 900	Continued From pa	ge 26	2 900			
	positioning needs for facility.	or residents in long term care				
	nutritional services, the dietitian would be monitoring and doc	y policy titled Pressure ulcers, reviewed 12/16/15, revealed be responsible for longing umentation of resident status with the presence of a				
	The director of nurs development and in procedures for the a for pressure ulcers. designee could then	HOD OF CORRECTION: sing or designee could explement policies and exppropriate care and services The director of nursing or expension monitor the appropriate staff expolicies and procedures.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty one				
21100	MN Rule 4658.0650 Storage of Perishab	Subp. 5 Food Supplies; ble food	21100			3/21/16
	perishable food must washable, corrosion	of perishable food. All st be stored off the floor on n-resistant shelving under and at temperatures which spoilage.				
	by: Based on observati review, the facility fa items in the kitchen resident's refrigerat	ent is not met as evidenced on, interview and document ailed to ensure open food 's refrigerator and the or located in the north dining and dated when opened. This		Corrected		

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			7t. Bolebiito.	A. BUILDING.			
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21100	Continued From pa	 ige 27	21100				
	had the potential to affect 23 of 24 residents who resided in the facility.						
	Findings Include:						
	revealed the middle cheddar cheese in around the package package), and the of was opened. Cook cheese was not see date on the package	a.m. the tour of the kitchen e refrigerator had a package of it with masking tape loosely e opening (but not sealing the cheese was not dated when it (C-A) verified the package of aled, and there was no open the C-A stated the cheese in a plastic container with a lid be dated.					
	north dining room of zip lock bag with or a circular black spot approximately 0.25 addition, in the same which had 3 dark of approximately 0.5 of then 0.5 cm and the There was a reside it was not dated. The brown pie box with last initial on it. The 12/28/15. The pie be addition, there was been opened but he 1/6/16. At 2:10 p.m stated the refrigerat used for the resider stated the oranges belonged to a residing the facility. RN-A a use by date of 12	p.m. the refrigerator in the contained a pealed orange in a ne section of 2 slices that had of in the center of it centimeters (cm) in size. In ne bag there was a 1/2 orange ircular areas on it; one area cm in size, one slightly smaller e 3rd area was pinpoint in size. In the first name on the bag, but ne refrigerator also contained a a resident's first name and a use date on the box was box contained 4 slices of pie. In a quart of eggnog that had not ad an expiration date of . registered nurse (RN-A) tor in the north dining room is not and their families. RN-A had mold on them and lent that was no longer residing a verified the blueberry pie had 1/28/15, and it should have RN-A stated the usual facility					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21100 Continued From page 28 practice was for housekeeping or maintenance to check the refrigerator daily and if the food is old or expired they would throw it away. RN-A stated if housekeeping or maintenance have concerns about the food or if they find outlated food in the refrigerator daily and confirmed the food items were available for the residents in the north dining room and were outdated. On 2/9/16, at 3:15 p.m. the dietitian (D)-D stated the expired blueberry pie, oranges with the dark spots and eggnog findings were not acceptable. D-D verified the food should have open dates on them and the moldy oranges discarded. D-D	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HENNING (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) 21100 Continued From page 28 practice was for housekeeping or maintenance to check the refrigerator daily and if the food is old or expired they would throw it away. RN-A stated if housekeeping or maintenance have concerns about the food or if they find outdated food in the refrigerator daily and confirmed the food items were available for the residents in the north dining room and were outdated. On 2/9/16, at 3:15 p.m. the dietitian (D)-D stated the expired blueberry pie, oranges with the dark spots and eggnog findings were not acceptable. D-D verified the food should have open dates on them and the moldy oranges discarded. D-D				A. BUILDING:			
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practice was for housekeeping or maintenance to check the refrigerator daily and if the food is old or expired they would throw it away. RN-A stated if housekeeping or maintenance have concerns about the food or if they find outdated food in the refrigerator they would throw it away and would tell nursing. RN-A stated they should be checking the refrigerator daily and confirmed the food items were available for the residents in the north dining room and were outdated. On 2/9/16, at 3:15 p.m. the dietitian (D)-D stated the expired blueberry pie, oranges with the dark spots and eggnog findings were not acceptable. D-D verified the food should have open dates on them and the moldy oranges discarded. D-D	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
stated the dining department was to check daily for outdated food and open dates on food, and it had not been done daily. D-D stated they should be labeling and dating food items and checking that food is not spoiled or has not expired daily. D-D stated the cook should check for expiration dates, labels and open dates on the food package. The daily cleaning schedule indicated the a.m. and p.m. cook was to remove outdated food items. Review of the facility January cleaning schedule from 1/4/16, to 1/31/16, identified the a.m. cook had not checked for outdated food items 16 out of 27 days and the p.m. cook had not checked for outdated food items 8 out of 27 days. Review of the February cleaning schedule from 2/1/16, to 2/9/16, identified the a.m. cook had not checked for outdated items 3 out of 9 days and the p.m. cook had not checked for outdated items 3 out of 9 days and the p.m. cook had not checked for outdated items 3 out of 9 days and the p.m. cook had not checked 1 out of 9 days. The facility policy titled Storage of Refrigerated Foods reviewed 2/12/15, had indicated to monitor	21100	practice was for ho check the refrigerator expired they wou if housekeeping or about the food or if refrigerator they wotell nursing. RN-As the refrigerator dail items were available dining room and we On 2/9/16, at 3:15 puthe expired blueber spots and eggnog for D-D verified the foot them and the mold stated the dining defor outdated food a had not been done be labeling and dat that food is not spood D-D stated the cood dates, labels and opackage. The daily the a.m. and p.m. of food items. Review of the facility from 1/4/16, to 1/31 had not checked fo 27 days and the p.r. outdated food items the February cleanic 2/9/16, identified the for outdated items are cook had not checked. The facility policy time facility policy to the facility policy to t	usekeeping or maintenance to tor daily and if the food is old ald throw it away. RN-A stated maintenance have concerns they find outdated food in the old throw it away and would stated they should be checking y and confirmed the food le for the residents in the northere outdated. p.m. the dietitian (D)-D stated rry pie, oranges with the dark findings were not acceptable. It is described as hould have open dates on y oranges discarded. D-D repartment was to check daily and open dates on food, and it daily. D-D stated they should ing food items and checking illed or has not expired daily. It is should check for expiration pen dates on the food cleaning schedule indicated cook was to remove outdated took was to remove outdated they January cleaning schedule indicated cook was to remove outdated took was to remove outdated form. Cook had not checked for so the food items 16 out of m. cook had not checked for so the food outdated food items 16 out of m. cook had not checked for so the food out of 9 days. Review of ing schedule from 2/1/16, to ea.m. cook had not checked out of 9 days and the p.m. and they are the food out of 9 days.				

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STATE FORM 5899 5RL311 If continuation sheet 29 of 51

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
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GOLDEN	I LIVINGCENTER - HE	-NNIN(-i	SHALL AVEN , MN 56551	IUE, PO BOX 57		
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21100	Continued From pa		21100			
	The director of dieta development and in procedures to ensu director of dietary s	THOD OF CORRECTION: ary services or designee could implement policies and re proper food storage. The ervices or designee could then riate staff for adherence to the lures.				
	TIME PERIOD FOR CORRECTION: Twenty one (21) days					
21390		Subp. 4 A-I Infection Control	21390			3/21/16
	Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents;					
	control of outbreaks C. isolation and reduce risk of trans D. in-service ed	detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection				
	immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as				

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21390	H. a system fo products which affed disinfectants, antise incontinence products. It methods for current standards of this MN Requirem by: Based on observations.	r review and evaluation of ect infection control, such as eptics, gloves, and	21390	Corrected		
	manner. This had t residents (R11, R30 shared container of glucose. Findings include: On 2/07/16, at 12:0 (RN)-B entered R1 container of glucon had no cover and the appearance of open areas on all focontainer directly o over-the-bed table.	as maintained in a sanitary he potential to effect 2 of 2 o				
	strip from the conta these items to chec carried the contains same gloved hands the top of the toilet soiled gloves, turne found no running w up the container of carried it back to the directly on the top of	I wipe, lancet and glucose iner. Following the use of the R11's blood glucose, RN-B er to the bathroom with the s, and placed the container on tank. RN-B removed the ed on the water faucet, and ater at this time. RN-B picked blood glucose supplies, e medication cart and placed it of the medication cart. RN-B ed lancet and blood glucose				

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21390	strip into a sharps of glucometer with a surveyor. On 2/07/16, at 12:2 had attempted to plucometer of the medication of the conot the usual facility containers onto understood on the usual facility containers onto understood on the over-the have been placed of further indicated the sanitized with a gerplacing it onto the toreturning it to the drown on the over-the sanitized with a gerplacing it onto the toreturning it to the drown on the over-the and agreed the multiple of the contaminated when resident's over-the-and agreed the multiple of sanitized beformedication cart. The expectation that the remain in the medication cart. The supply basket is [medication] cart." The facility policy titof Resident-Care Ital/11/15, identified	container, and sanitized the permicidal bleach wipe. RN-A container into the top drawer art with other resident and was stopped by the O p.m. RN-B verified he/she ace the container into the top cation cart without sanitizing ontainer. RN-B identified it was a practice to place multi-use clean surfaces nor was it usuant item to the medication cart. RN-B indicated the multi-use are been placed onto a paper ne-bed table, and should not on top of the toilet tank. RN-B are bin should have been micidal bleach wipe before op of the medication cart and rawer. p.m. the director of nursing container became a placed on top of the bed table and the toilet tank, ati-use container should have been returning it to the end container of supplies would cation cart. The DON stated should never leave the med alled Cleaning and Disinfection tems and Equipment, reviewed the resident care equipment and disinfected according to				

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21390	recommendations. The CDC web page and Sterilization in lidentified "The ultim Recommendations Sterilization in Heal reduce rates of heathrough appropriate sterilization." SUGGESTED METHE The director of nurse the pertinent policie infection control promulti-use resident in provided to the staf committee could defectiveness of the	e Guideline for Disinfection Healthcare Facilities, 2008, nate goal of the for Disinfection and th-Care Facilities, 2008, is to alth-care-associated infections are use of both disinfection and THOD OF CORRECTION: sing or designee could review as and procedures for ensuring ocedures were maintained with tems. Education could be be f. The quality assurance evelop a system to monitor the				
21426	MN St. Statute 144. Prevention And Cor (a) A nursing home maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla	A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students,	21426			3/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	·NNING	SHALL AVEN i, MN 56551	NUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21426	residents, and volui Health shall provide regarding implemen	nteers. The Department of e technical assistance ntation of the guidelines.	21426			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculin symptom screenings and two step skin test for tuberculosis (TB) were provided for 2 of 6 newly hired employees (E1) and the director of nursing (DON) in the sample.			Corrected		
	symptom screen or The DON had a hird symptom screen was was administered of 2/7/16, fifty five day On 2/9/16, at 3:00 p (DON) verified a not implemented and n completed for her u was recently admin documentation of s could be found for 8 symptom screen sh	of 1/5/16, no records of a TB skin tests were found. e date of 12/14/15, no as found and the first skin test in the survey entry date of safter hire. o.m. the director of nursing lew form for TB had been o symptom screen had been upon hire, and the first skin test istered. The DON verified no symptom screen or skin tests istered. The DON agreed a mould have been completed by skin test upon hire and the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	·NNING	, MN 56551	IOL, FO BOX 37		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 34	21426			
	records should have	e been maintained.				
	Employees and Ne Identified Policy Sta be screen [sik] for t disease, using a tw (TST) or blood assa	elled Tuberculosis, Screening w Hires reviewed 8/14/15, atement: All employees shall uberculosis (TB) infection and o-step tuberculin skin test ay for Mycobacterium and symptom screening, mployment.				
	The DON or adminiupdate procedures	THOD FOR CORRECTION: istrator could review and and educate staff to ensure ecommendations for acticed.				
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			3/21/16
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adeces in the prese which indicate the condition to the discontinued. In addition to the discontinued in additional discont	al. A resident's drug regimen unnecessary drugs. An sany drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - HE	·NNING	SHALL AVEI 3, MN 56551	NUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Long-Term Care Fa Department of Heal Health Care Finance This standard is income available through the system and the State subject to frequent This MN Requirement by: Based on observation review, the facility for the fectiveness of an medication for 1 of obsessive compuls. Findings include: R30's quarterly Min 1/18/16, identified For the had no behaviors, for the fective decare, and physical for the fective decare which included care which inc	acilities, published by the lth and Human Services, ing Administration, April 1992. Torporated by reference. It is the Minitex interlibrary loan the Law Library. It is not change. The most met as evidenced on, interview, and document alled monitor the ongoing antidepressant (Celexa) is residents (R30) utilized for the disorder. The most met as evidenced on, interview, and document alled monitor the ongoing antidepressant (Celexa) is residents (R30) utilized for the disorder. The most met as evidenced on, interview, and document alled monitor the ongoing antidepressant (Celexa) is residents (R30) utilized for the disorder or delusions the period. The most met as evidenced on, interview, and document alled monitoring of the disorder or and monitoring of those or and monitoring of those or and monitoring of the dentified R30 received Celexa daily for the diagnoses of impulsive disorder)/anxiety (18/15).	21535	Corrected		
	revealed R30 had b	een started on Celexa 10mg ty for delusions of greens				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	·NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 36	21535			
		ve thoughts of cleaning her ed to occupy her thoughts and				
	revealed R30's dos	ycian note dated 11/17/15, e of Celexa had been daily for continued delusions				
	2/2/16 and review of Record (TAR) and I Record (MAR) Janu documentation of m	nical record, 11/19/15 through of the Treatment Administration Medication Administration wary and February, lacked nonitoring of the effect of mehaviors for the diagnosis of				
	nursing (ADON) verice Celexa 20 mg daily behaviors with a state ADON verified the caddress R30's use The ADON indicate OCD staff had been target behaviors and medications into the ADON identified the and document ever effects were present progress note explain behavior and/or sidentified the cand document of the cand document ever effects were present progress note explain behavior and/or sidentified the cand document ever effects were present progress note explain behavior and/or sidentified the candidate of t	p.m. the director of nursing				
	(DON) indicated R3 included the use of and interventions. T	00's care plan should have Celexa, with target behaviors The DON verified uld have been completed for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7 50.25.1143.			
		00799	B. WING		02/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(-	, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	SUGGESTED MET The director of nurs review and revise p to ensuring medica director of nursing of system to educate system to ensure re unnecessary medic	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related tion regimen review. The or designee could develop a staff and develop a monitoring esidents are not receiving	21535			
21540	Subp. 2. Monitoring monitor each reside unnecessary drug thome's policies and pharmacist must reresident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, to review to the Qualit (QAA) committee rethe attending physician physician physician does not the attending physician physician does not the dualit (QAA) committee rethe attending physician physician physician physician physician does not the attending physician physician does not the attending physician physician does not the attending physician does not the	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the eport any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer the eal director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter	21540			3/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - HE	- 10101101	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 38	21540			
	directly to the QAA.					
	by: Based on interview facility consulting pl irregularity for 1 of ongoing monitoring antidepressant (Ce treat obsessive con	ent is not met as evidenced and document review, the harmacist failed to identify the 1 residents (R30) who lacked of the effectiveness of an lexa) medication ordered to npulsive disorder.		Corrected		
	Findings include:					
	R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 was cognitively intact and had no behaviors, hallucinations or delusions during the assessment period.					
	care which included care, and physical f address the use of	plan revised 5/16, directed d: diabetes, activities, oral functioning, however, did not Celexa related to obsessive or and monitoring of those				
	physician 1/14/16, i 20 milligrams (mg)	cation orders signed by the dentified R30 received Celexa daily for the diagnoses of empulsive disorder)/anxiety /18/15.				
	revealed R30 had be daily for OCD/anxie worms and obsession	ysician note dated 11/3/15, been started on Celexa 10mg ety for delusions of greens eve thoughts of cleaning her ared to occupy her thoughts and				
	Review of R30 phys	sician note dated 11/17/15.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 20.22			
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(-	SHALL AVEN 6, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	revealed R30's dos increased to 20 mg and hallucinations. Review of R30's cli 2/2/16 and review of Record (TAR) and Record (MAR) Jand documentation of n Celexa related to b OCD. Review of R30's pro 2/10/16 revealed the dose increased to 2 anxiety, appears to monitor. -1/15/16, no recom On 2/10/16, at 11:0 nursing (ADON) veclexa 20 mg daily behaviors with a sta ADON verified the address R30's use The ADON indicate OCD staff had been target behaviors an medications into the ADON identified the and document ever effects were preser	e of Celexa had been daily for continued delusions nical record, 11/19/15 through of the Treatment Administration Medication Administration wary and February, lacked nonitoring of the effect of behaviors for the diagnosis of ogress notes from 11/16/15 to be following pharmacy notes: placed on citalopram (Celexa), 20 mg 11/15 to help manage tolerate. Will continue to				
		p.m. the director of nursing 80's care plan should have				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		02/10/2016	
NAME OF F	PROVIDER OR SUPPLIER		L DRESS, CITY, S	STATE, ZIP CODE	V = / 1	0/2010
GOLDEN	I LIVINGCENTER - HE	-NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 40	21540			
	included the use of Celexa, with target behaviors and interventions. The DON verified documentation should have been completed for monitoring of side effects.					
	consulting pharmac	p.m. a call was placed to the cist for interview and message call was received during or urvey.				
	The requested facil	ity policy was not provided.				
	director of nursing of pertinent policies ar monitoring. Educat the staff. The quali	THOD OF CORRECTION: The or designee could review the nd procedures for medication tion could be be provided to ty assurance committee could o monitor the effectiveness of				
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one				
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			3/21/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by:	ent is not met as evidenced on, interview, and document		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEI	N LIVINGCENTER - HE	-NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21805	review, the facility facignity during leisur for 1 of 3 residents gait belt for ambula. Findings include: R24's quarterly Min 11/18/15, identified impairment, require staff for personal hy transferring. R24's Care Area As 8/28/15, identified of cerebral vascular and depression, and ha R24's current care R24 had visual defined deficit and had physolan listed various is staff assistance with and walker related encourage choices and guidance. Observations on 2/3 - At 3:55 p.m. R24 nursing assistant (Nowheeled walker and around his/her waist. R24 in this/her waist.	ailed to ensure personal re activities and meal service (R24) observed to utilize a tion. imum Data Set (MDS) dated R24 had moderate cognitive and extensive assistance from regione, dressing, toileting and research (CAA) dated diagnoses which included accident, blindness, and of hearing. plan revised 1/28/16, identified acit due to blindness, hearing regional impairments. R24's care anterventions which included to blindness, explain cares, with cares, offer verbal cues 8/16, identified the following: It was assisted to walk by NA)-E. R24 walked with a di wore a dark blue gait belt st. was observed seated in a at able in the dining room. remained fastened around	21805			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(i	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 42	21805			
	the table in front of	R24.				
	side of R24. NA-E explained coffee, commerce available on the series of	sat at the table to the right offered R24 a drink and then hocolate milk and orange juice he table in front of R24. Estood from the table and dents in the dining room with drinks and meals. R24 the table with the dark blue round his/her waist. acility Dietitian delivered R24's sat to the right side of R24 at A-A assisted R24 with eating, ems were, handing utensils to R24 and spooning foods nouth. The dark blue gait belt around R24's waist ning meal service.				
	-At 6:12 p.m. NA-A away from the table in front of R25 and NA-A guided R24 to room. NA-A did not R24 to walk. NA-A right side of R24's vleft front side of the his/her room. -At 6:15 p.m. NA-A assisted R24 into tof the wheeled walkAt 6:25 p.m. R24 v	turned R24's stationary chair e, placed the wheeled walker assisted him/her to stand. It walk through the dining grasp the gait belt to assist instead held on to the front wheeled walker, and then the walker until R24 had reached grasped the gait belt and he bathroom without the use				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 20.22.110.1			
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - HE	-NNIN(-	SHALL AVEN 6, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	draped over R24's listening to the televremained fastened -At 7:07 p.m. the diassisted R24 to donand walk down the for bingo. The DON room down the hall remained fastened throughout the every ching room between resident who was in friend. The dark bluaround R24's wais the bingo game whom. On 2/08/16, at 6:28 the gait belt on thro R24 currently conting while laying in bed. gait belt remaining NA-A stated "[R24] hour." NA-A indicated at the front lobby with time the gait belt was "[R24] has never congait belt for extended observations on 2/2 -At 2:54 p.m. NA-F the hall from his/he cookies and coffee.	legs. R24 had head phones on vision. The dark blue gait belt around R24's waist. rector of nursing (DON) on slippers, rise from the bed hall towards the dining room I walked R24 from his/her with the gait belt which had around R24's waist ning. vas seated at a table in the enthe bingo caller and a dentified by R24 as a personal are gait belt remained fastened at throughout the observation of ich was completed at 7:51 B p.m. NA-A verified R24 had ughout the evening meal, and nued to have the gait belt on When questioned about the fastened around R24's waist will go down to bingo in a half ed that R24 did not always astened around his/her waist. imes R24 had been seated in a female resident and at that as loosened. NA-A stated omplained" about wearing the		DEL ROILNOI)		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(-	SHALL AVEN , MN 56551	UE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 44	21805			
	gait belt remained f through the snack a	astened around R24's waist and visiting time.				
	stationary chair by	vas seated in the lobby in a the wall with a female resident. pelt remained around R24's				
	utilized a gait belt to provide safety. NA- while at the facility; possibly may go ou NA-B identified it w practice to leave a resident's waist who resident. NA-B veri	45 a.m. NA-B identified R24 or assist with walking and to B indicated R24 had not fallen however, had a knee that trand R24 saw only shadows, as not the usual facility gait belt fastened around a en not walking with the fied the gait belt should have in R24 was seated in the				
		50 p.m. the DON verified gait noved from around a resident's not walking.				
	a gait belt on at this visiting with a fema R24 utilized a gait be walking. NA-G indicatened around R2	B p.m. NA-G verified R24 had a time while seated in the lobby le resident. NA-G identified pelt for all transfers and cated gait belts were only 24's waist when being used off when [R24] sits down, or				
	indicated staff ofter R24's waist and it v R24 stated staff ha belt around R24's v	a.m. during interview, R24 napplied the gait belt around would remain in place all day. d not asked if leaving the gait waist bothered [R24]." R24 pok like hell, I can't see to take				

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AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:				(X3) DATE COMP	E SURVEY PLETED	
		00799	B. WING		02/1	0/2016
	PROVIDER OR SUPPLIER	NNING 907 MARS		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	reviewed 1/26/15, or belt; however, the part the gait belt was to SUGGESTED MET. The director of nurs development and in procedures to ensur with dignity. The director adherence to the part of the p	led Transfer Activities, lirected staff with use of a gait solicy did not address when	21805			
21830	Residents of HC Fasubd. 10. Particip notification of family (a) Residents shall in the planning of the includes the opport alternatives with incopportunity to requestare conferences, a family member or oboth. In the event to present, a family member or oboth. In the event to present, a family member or oboth. In the event to present, a family member or oboth. In the event to present, a family member or oboth. In the event to present, a family member or oboth. In the event to present, a family member or oboth. In the event to present, a family member or oboth. In the event to present the event the event the event to present the event t	pation in planning treatment;	21830			3/21/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00799		B. WING		02/10/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - HE	-NNING	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	writing by the reside an emergency that admitted to the faci family member to pplanning, unless the to believe the reside directive to the conspecified in writing member included in notifying a family member to pplanning, the facility efforts, consistent with practice, to determine executed an advance sident's health care this paragraph, "rea (1) examining the resident; (2) examining the resident in the possion (3) inquiring of an family member conswhether the resider directive and whether the resider directive and whether the resider directive. If a facility designated emergency with the iliable to resident for the notification of the mergency contact.	ent as the person to contact in the resident has been lity. The facility shall allow the articipate in treatment er facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a participate in treatment y must make reasonable with reasonable medical interestive relative to the redecisions. For purposes of asonable efforts" include: the personal effects of the resident has a the resident has a the resident has a the resident normally goes for the physician to whom the oes for care, if known, and has executed an advance are the resident or allows a family member or ency contact or allows a family attein treatment planning in its paragraph, the facility is not redamages on the grounds that the family member or or the participation of the simproper or violated the	21830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		D WING				
00799			B. WING		02/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HE	-NNIN(-	, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.		21830			
	by: Based on interview facility failed to acc preferences for bat	and document review, the ommodate resident hing for 2 of 2 residents (R30, pathing preferences.		Corrected		
	Findings include: R30 indicated on 2/07/16, at 4:29 p.m. he/she received a bath two times a week and stated "I really should have a bath every day" because of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00799	B. WING		02/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE IUE, PO BOX 57		
GOLDEN	I LIVINGCENTER - HE	- NININC -	i, MN 56551	IOL, TO BOX 07		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 48	21830			
	incontinence of loos	se stools.				
	1/18/16, identified F required extensive mobility, toilet use, was frequently inco The physician programmer.	imum Data Set (MDS) dated R30 had intact cognition, assistance with transfers, hygiene and dressing, and ntinent of bowel and bladder. ress note dated 11/3/15, s which included incontinence, cancer.				
		y bath schedule February 1 , noted R30 had received two sday and Sunday.				
	On 2/10/16, at 8:47 a.m. NA-D indicated R30 had intact memory, received a bath two times a week on Sundays and Thursdays. NA-D identified if residents asked for additional baths staff tried to fulfill the request or would pass it on to the next shift. NA-D stated "[R30] tells me [he/she] wished [he/she] could have a bath every day,we try but most times can't." NA-D identified since the beginning of November staffing had been cut; however, R30 was not given more baths prior to having less staff scheduled. NA-D stated "We don't have time."					
	received a bath one told them I would like have too many peo	12:00 p.m. identified he/she be a week. R11 stated "I have ke more and they said they ple." R11 indicated he/she se and the bath aide to request a per week.				
	identified diagnoses	rogress note dated 11/24/15, s which included super-morbid bility, peripheral neuropathy, ase and diabetes.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HENNING B. WING			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			00799	B. WING		02/1	0/2016
HENNING, MN 56551	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	GOLDE	N LIVINGCENTER - HE	-NNING-		IUE, PO BOX 57		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
21830 Continued From page 49 R11's admission MDS assessment dated 11/27/15, identified R11 had intact cognition, and required extensive assistance with transfers, mobility, toilet use, hygiene and dressing, was frequently incontinent of bowel and bladder, and required total assistance with bathing. The nursing assistant care sheets identified R11 was frequently incontinent of bowel and bladder and received a bath on Wednesdays. Review of the bath schedule February 1 through February 9, noted R11 had received one bath a week, on Wednesday. On 2/09/16, at 10:55 a.m. NA-B identified R11 was unable to go into the bathroom to wash. NA-B indicated R11 was given a wash cloth and a towel to wash daily and received a tub bath one time a week. On 2/10/16, at 8:31 a.m. The licensed social worker (LSW)-F identified she did not coordinate resident bathing schedules. LSW-F indicated the nurses scheduled bathing and reviewed preferences. LSW-F identified her involvement with bathing was to inquire resident preferences of tub baths versus showers and how important the choice is to the resident, for documentation on the MDS. On 2/10/16, at 11:33 a.m. the assistant director of nursing (ADON) identified a bathing schedule was initiated upon admission to the facility; however, if a resident voiced a request for more baths staff would try to accommodate the request. The ADON indicated being unaware R30 or R11 had made requests for more baths. On 2/10/16, at 1:55 p.m. the director of nursing	21830	R11's admission M 11/27/15, identified required extensive mobility, toilet use, frequently incontine required total assis The nursing assista was frequently inco and received a bath the bath schedule froted R11 had received wednesday. On 2/09/16, at 10:5 was unable to go in NA-B indicated R11 towel to wash daily time a week. On 2/10/16, at 8:31 worker (LSW)-F ideresident bathing scrurses scheduled by preferences. LSW-with bathing was to of tub baths versus the choice is to the on the MDS. On 2/10/16, at 11:3 nursing (ADON) ide was initiated upon a however, if a reside baths staff would trrequest. The ADON or R11 had made received as the control of R11 had made received as t	MDS assessment dated R11 had intact cognition, and assistance with transfers, hygiene and dressing, was ent of bowel and bladder, and tance with bathing. ant care sheets identified R11 ontinent of bowel and bladder non Wednesdays. Review of February 1 through February 9, eived one bath a week, on served one bath a week, on the bathroom to wash. If was given a wash cloth and a and received a tub bath one a.m. The licensed social entified she did not coordinate hedules. LSW-F indicated the bathing and reviewed F identified her involvement inquire resident preferences a showers and how important resident, for documentation a.m. the assistant director of entified a bathing schedule admission to the facility; ent voiced a request for more y to accommodate the N indicated being unaware R30 equests for more baths.				

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		7.11.20125.11.01				
		00799	B. WING		02/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - HE	- NNIN(-	, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21830	or shower per week issues or a request The DON stated "If make every effort to Don verified the use honor resident requested facil SUGGESTED MET The director of nurs development and ir procedures to ensu choices in their dail nursing or designed appropriate staff for procedures.	a unless they had incontinence for more baths or showers. a resident requests more, we be accommodate them." The ual facility practice was to	21830			

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