DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MED	ICARE & MEDICAID SERVICES
MEDIC	ARE/MEDICAID CERTIFICATION A	AND TRANSMITTAL	ID: 76C4
PART I -	TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 00943
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245148	3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - ST LC	DUIS PARK PLAZA	 TYPE OF ACTION: <u>7</u> (L8) Initial Recertification
 STATE VENDOR OR MEDICAID NO. (L2) 428658800 	(L4) 3201 VIRGINIA AVENUE SOUTH (L5) SAINT LOUIS PARK, MN	(L6) 55426	3. Termination4. CHOW5. Validation6. Complaint
 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006 	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 02/26/2016 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
From (a):	X A. In Compliance With	And/Or Approved Waivers Of T	The Following Requirements:
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel 3. 24 Hour RN	 6. Scope of Services Limit 7. Medical Director
	1. Acceptable POC	4. 7-Day RN (Rural SN	F) 8. Patient Room Size
12. Total Facility Beds 208 (L18) 13. Total Certified Beds 208 (L17)	D. Not in Compliance with Dream	5. Life Safety Code	9. Beds/Room
13.Total Certified Beds 208 (L17)	 B. Not in Compliance with Program Requirements and/or Applied Waivers: 	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
208			
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	ABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Gloria Derfus, Unit Supervisor	03/02/2016 (L19)	Kamala Fiske-Downing, E	Enforcement Specialist 03/03/2016 (L20)
PART II - TO BE	COMPLETED BY HCFA REGIONAL	OFFICE OR SINGLE ST	
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finan	
1. Facility is Eligible to Participate	RIGHTS ACT:	 Ownership/Control Both of the Above 	I Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible			
(L21)			
22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING 03/01/1968	G DATE ENDING DATE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS	03-Risk of Involuntary Termination	¹ OTHER
A. Suspensio	n of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change
(L27) D. Passind S	(L44)		00-Active
(L27) B. Rescind S	uspension Date:		
	(L45)		
28. TERMINATION DATE: 29	9. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	00450		
(L28)	(L31)		
31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPR	ROVAL



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245148

March 2, 2016

Mr. Timothy Johnson, Administrator Golden LivingCenter - St Louis Park Plaza 3201 Virginia Avenue South Saint Louis Park, MN 55426

Dear Mr. Johnson:

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 February 23, 2016 the above facility is certified for:

208 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 208 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

March 2, 2016

Mr. Timothy Johnson, Administrator Golden LivingCenter - St Louis Park Plaza 3201 Virginia Avenue South Saint Louis Park, MN 55426

Re: Reinspection Results - Project Number S5148025

Dear Mr. Johnson:

On February 26, 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 26, 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.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		1	DATE OF REVISI	IT
IDENTIFICATION NUMBER	A. Building				
245148 _{Y1}	B. Wing	Y2	2	2/26/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH			
		SAINT LOUIS PARK, MN 55426			

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			DATE Y5	ITEM Y4			DATE Y5
¥4		15	Y4			15	¥4			15
ID Prefix	F0241	Correction	ID Prefix	F0246		Correction	ID Prefix	F0258		Correction
Reg. #	483.15(a)	Completed	Reg. #	483.15(6	9)(1)	Completed	Reg. #	483.15(h)(7)		Completed
LSC		02/23/2016	LSC			02/23/2016	LSC			02/23/2016
ID Prefix	F0278	Correction	ID Prefix	F0279		Correction	ID Prefix	F0282		Correction
Reg. #	483.20(g) - (j)	Completed	Reg. #	483.20(0	d), 483.20(k)(1)	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC		02/23/2016	LSC			02/23/2016	LSC			02/23/2016
ID Prefix	F0312	Correction	ID Prefix	F0314		Correction	ID Prefix	F0315		Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	483.25(0	:)	Completed	Reg. #	483.25(d)		Completed
LSC		02/23/2016	LSC			02/23/2016	LSC			02/23/2016
ID Prefix	F0323	Correction	ID Prefix	F0353		Correction	ID Prefix	F0371		Correction
Reg. #	483.25(h)	Completed	Reg. #	483.30(a	a)	Completed	Reg. #	483.35(i)		Completed
LSC		02/23/2016	LSC			02/23/2016	LSC			02/23/2016
ID Prefix	F0372	Correction	ID Prefix	F0431		Correction	ID Prefix	F0441		Correction
Reg. #	483.35(i)(3)	Completed	Reg. #	483.60(k	o), (d), (e)	Completed	Reg. #	483.65		Completed
LSC		02/23/2016	LSC			02/23/2016	LSC			02/23/2016
REVIEW		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF				DATE	0040
REVIEW CMS RO		GD/kfd REVIEWED BY (INITIALS)	03/02/20 DATE		TITLE	18623			2/26/. DATE	2016

Form CMS - 2567B (09/92) EF (11/06)

EVENT ID: 76C412

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	IT
	B. Wing	Y2	2	2/26/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - ST	LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH			
		SAINT LOUIS PARK, MN 55426			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM		ATE	ITEM	DATE
Y4	Y5	Y4		Y5	Y4	Y5
ID Prefix F0465	Correction	ID Prefix For	514 Cor	rection		
Reg. # 483.70(h)	Completed	Reg. # 483	.75(l)(1) Cor	npleted		
LSC	02/23/2016	LSC	02/2	23/2016		
					_	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SUR	VEYOR		DATE
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE
FOLLOWUP TO SURVE 1/14/2016	Y COMPLETED ON		OR ANY UNCORRECTED RECTED DEFICIENCIES (C	DEFICIEN CMS-2567)	ICIES. WAS A SUMMAF SENT TO THE FACILIT	

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REVIS	IT
	B. Wing	Yź	2	2/29/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - ST	LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH			
		SAINT LOUIS PARK, MN 55426			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC K0054	02/23/2016	LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR		DATE	
	TL/kfd	03/02/2016		1925 <i>°</i>	1		9/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVE 1/12/2016	Y COMPLETED ON		R ANY UNCORREC	TED DEFICIEN ES (CMS-2567)	NCIES. WAS A SENT TO TH		s 🗌 no

DEPARTMENT OF HEALTH AND	HUMA	N SERVICES	CENTERS FOR MEI	DICARE & MEDICAID SERVICES
I	MEDIC	ARE/MEDICAID CERTIFICATIO	ON AND TRANSMITTAL	ID: 76C4
F	ART I -	TO BE COMPLETED BY THE S	TATE SURVEY AGENCY	Facility ID: 00943
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245148		3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - S	T LOUIS PARK PLAZA	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L2) 428658800		(L4) 3201 VIRGINIA AVENUE SOUT (L5) SAINT LOUIS PARK, MN	(L6) 55426	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERS (L9) 04/01/2006	SHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ES	<u>02</u> (L7) SRD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 01/14/2016 8. ACCREDITATION STATUS:	(L34) (L10)	02 SNF/NF/Dual 06 PRTF 10 N 03 SNF/NF/Distinct 07 X-Ray 11 IC	F 14 CORF F/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited1 TJC2 AOA3 Other		04 SNF 08 OPT/SP 12 RI	HC 16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY IS CERTIFIED AS:		·
From (a): To (b):		A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of 2. Technical Personnel	6. Scope of Services Limit
12. Total Facility Beds 208	(L18)	1. Acceptable POC	3. 24 Hour RN 4. 7-Day RN (Rural SN	
13.Total Certified Beds 208	(L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers	5. Life Safety Code : * Code: B *	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS	
18 SNF 18/19 SNF 208	19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (II 17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Eva Loch, HFE NE II		02/05/2016 _{(L1}	9) Kamala Fiske-Downing, I	Enforcement Specialist 03/02/2016 (L20)
PART II -	TO BE	COMPLETED BY HCFA REGIO	NAL OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate		20. COMPLIANCE WITH CIVII RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) 2 :
2. Facility is not Eligible	(L21)			
22. ORIGINAL DATE 23. LT	C AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BI 03/01/1968	EGINNINC	G DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure 0	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24) (L	41)	(L25)	02-Dissatisfaction W/ Reimburse	
		VE SANCTIONS n of Admissions:	03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	07-Provider Status Change
(L27) B.	Rescind S	(L44) uspension Date:		00-Active
		(L45)		
28. TERMINATION DATE:	29	D. INTERMEDIARY/CARRIER NO.	30. REMARKS	
		00450		
(L28)	(L3	1)	
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION OF APPROVAL DATE		
(L32)	(L3:	3) DETERMINATION APPI	ROVAL



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered January 29, 2016

Mr. Timothy Johnson, Administrator Golden LivingCenter - St Louis Park Plaza 3201 Virginia Avenue South Saint Louis Park, MN 55426

RE: Project Number S5148025

Dear Mr. Johnson:

On January 14, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5148155 that was found to be unsubstantiated.

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

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

<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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 23, 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 February 23, 2016 the following remedy will be imposed:

• Per instance civil money penalties. (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

Golden LivingCenter - St Louis Park Plaza January 29, 2016 Page 3

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

Golden LivingCenter - St Louis Park Plaza January 29, 2016 Page 4

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 April 14, 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 July 14, 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 Golden LivingCenter - St Louis Park Plaza January 29, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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 State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumalu Piske Downing

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

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERCIA (X2) MULTIPLE CONSTRUCTION (X2) DATE SURVEY COME NO. 0938-0391 AMD PUANOF COMPECTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA SUMMARY STATEMENT OF DEFICIENCIES PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES PRESUL SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETION PRESULT TAG SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETION F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 COMPLETION SUMDISSION of the POC will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to	DEPART	MENT OF HEALTH	AND HUMAN SERVICES			M APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A.BUILDING COMPLETED AXE OF PROVIDER OR SUPPLIER 245148 B. WING 01/14/2016 MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINA ARENUE SOUTH SAINT LOUIS PARK, MN 55426 (X4, ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CAOSE REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETED F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve any sour allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CNK-32567 F 000 INITIAL COMMENTS F 000 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance. ID BURCETOR, and 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. F 241 483.15(a) DIGNITY AND RESPECT OF F 241 F 241 K31.5(a) DIGNITY AND RESPECT OF F 241 2/23/16 2/23/16	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB N	O. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, CITY, STATE, ZIP CODE Yaj ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (%) COMPLETION DATE F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 000 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with he regulations has been attained in accordance with your verification. F 241 At the time of the standard survey completed on January 14, 2016, an investigation of complaint number H5148155 was conducted and found to be unsubstantiated. F 241 F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY F 241						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG OPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the botom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 000 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. F 241 At the time of the standard survey completed on January 14, 2016, an investigation of complaint number H5148155 was conducted and found to be unsubstantiated. F 241 F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY F 241			245148	B. WING		1/14/2016
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA SAINT LOUIS PARK, MN 55426 (a) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDEN'S PLAN OF CORRECTION (EACH DEFICIENCY NUT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDEN'S PLAN OF CORRECTION (EACH DEFICIENCY) COMPLETON DATE F 000 INITIAL COMMENTS F 000 F 000 F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 000 INITIAL communication of compliance. 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. F 241 2/23/16 F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY F 241 2/23/16	NAME OF F	PROVIDER OR SUPPLIER				
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 000 INITIAL COMMENTS F 000 F 000 F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Image: Completed on January 14, 2016, an investigation of complaint number H5148155 was conducted on January 14, 2016, an investigation of complaint number H5148155 was conducted and found to be unsubstantiated. F 241 Z/23/16	GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA			
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.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.F 2412/23/16F 241 SS=DK315(a) DIGNITY AND RESPECT OF INDIVIDUALITYF 2412/23/16	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
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manner and in an environment that maintains or		as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substar regulations has beet your verification. At the time of the st January 14, 2016, a number H5148155 be unsubstantiated 483.15(a) DIGNITY INDIVIDUALITY The facility must pro-	of compliance upon the phance. Because you are your signature is not required first page of the CMS-2567 in submission of the POC will ion of compliance. acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with andard survey completed on an investigation of complaint was conducted and found to AND RESPECT OF	F 24	1	2/23/16
This REQUIREMENT is not met as evidenced		by: Based on observat review, the facility fa dinning for 1 of 1 re assisted with eating feeding R181. Findings include:	ion, interview, and document ailed to provide dignified sident (R181) observed being g by staff who stood while		does not constitute an admission of or agreement with the facts and conclusion set forth on the survey report. Our Plan Correction is prepared and executed as means to continuously improve the qual of care and to comply with all applicable	s of a ty
Based on observation, interview, and document review, the facility failed to provide dignified dinning for 1 of 1 resident (R181) observed being assisted with eating by staff who stood while feeding R181.Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable			ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Based on observation, interview, and document review, the facility failed to provide dignified dinning for 1 of 1 resident (R181) observed being assisted with eating by staff who stood while feeding R181. Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	Electron	ically Signed				02/04/2016

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.

PRINTED: 03/02/2016

		& MEDICAID SERVICES			1	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	age 1	F 241			
	R181's speech the	rapy clarification diet order ected staff that R181 was to		state and federal regulatory	requirements.	
	R181's admission I 12/22/15, indicated cognitive impairme assistance with eat included traumatic R181's care plan d encourage indepen- resident as needed During observation nursing assistant (I R181 pureed turke and pureed green b beverage. NA-D wa entire time NA-D wa During interview on stated, "I thought I stood while feeding	on 1/11/15, at 6:35 p.m. NA)-D was observed feeding y, mashed potatoes with gravy beans and a honey thick as observed standing the as feeding R181. 1/13/16, at 2:55 p.m. NA-D could feed more quickly if I I [R181]. I did not talk to er told me I could not stand		 F 241 a. R 181 assessment for feassistance reviewed and remcurrent for resident. b. Audit of all residents to in that need assistance with feac. All staff that assist with feducated to the Eating Supp procedure. d. DNS or designee to comaudit of 5 residents receiving support for dignified meal ex Audit results will be reviewed QAPI meeting and the freque will be changed depending of the audits. 	nained dentify those eding. eeding ort plete weekly eating perience. d at monthly ency of audits	
	During interview on director of nursing that staff would sit The facility Eating S 1/26/15, instructed resident feel that th that the procedure	a 1/14/16, at 3:00 p.m. the stated it was her expectation while feeding residents. Support procedure dated staff: "Never make the be meal must be hurried, but is pleasant. Give him/her your Sit so you are at the same				
F 246	level as the resider		F 246			2/23/16

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 03/02/2016 M APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245148	B. WING	i		1/14/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=E	OF NEEDS/PREFE A resident has the r	RENCES	F	246		
	preferences, excep	f individual needs and t when the health or safety of er residents would be				
	by: Based on observat review, the facility fa was within reach ar resident (R125), wh assistance from sta 3 of 4 residents (R1 appropriate season reviewed for activiti Findings include: R125 was observed during the interview observed laying on bed. When asked if light to ask for help the time. R125 state at the time. -At 4:11 p.m. licens stated R125 used h staff in. LPN-A wen verified the call ligh it off the floor and p sure it worked and	NT is not met as evidenced tion, interview, and document ailed to ensure the call light and available for use for 1 of 1 to utilized their call light for off. In addition failed to ensure (9, R153, R181) had and proper fitting clothing es for daily living (ADLs) d on 1/11/16, at 4:10 p.m. and R125's call light was the floor at the base of the she was able to use the call resident stated she used it all ed she was not able to reach it ed practical nurse (LPN)-A her call light at times to call t to room with surveyor and t was not at reach, then pulled ushed the button to make handed it to R125. When ble to use the call light R125 time."			 F 246 a. R125 room rearranged to ensure calight placement within reach of resident. R19 guardian was contacted by facility regarding clothing needs and they will be providing resident with money to purchase alternate clothing. R153 guardian was contacted and gave permission to sort through clothing and permission to sort through clothing with resident and help resident purchase new clothing. b. R125 care plan reviewed and revise relating to call light with in reach. R19, R153 and R181 care plans will be reviewed and revised to reflect residents preferred attire. Will review all care plan for accommodation of needs for call light placement within reach of resident, and identifying residents clothing needs and communicating this to IDT for assistance 	e Se d

Facility ID: 00943

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		à		PLETED
		245148	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
GOLDEN	I LIVINGCENTER - ST	I LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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)	OULD BE	(X5) COMPLETIC DATE
F 246	-At 4:13 p.m. when put at reach when on nursing assistant (I as he had left the roother NA. R125's fall Care Ar 8/13/15, indicated roother NA. R125's fall Care Ar 8/13/15, indicated roother coming to nursing I used a mechanical for falls with potent injury and further d The fall care plan co was at risk for falls laceration from falls impaired cognition, had generalized we directed staff to ensive were available and On 1/14/16, at 2:00 services (DNS) sta plan indicating the at reach then it was reach. Call light policy rev sure all call lights a times, never on the R19 was dressed in winter weather and	asked if call light had been observed early assisting R125 NA)-A stated he was not sure oom and was going to ask the ea Assessment (CAA) dated resident had fall prior to home. CAA indicated R125 lift for all transfers, was at risk ial for fracture and/or serious ebilitation. dated 8/13/15, indicated R125 , had sustained head s, had history of falls, had impaired physical ability and eakness. The care plan sure call light or personal items	F 24	with purchasing and sorting the clothing. d. ACD or SSD or designee to weekly audit of 5 residents for placement and clothing needs. results will be reviewed at more meeting and the frequency of a be changed depending on the the audits.	o complete call light Audit thly QAPI audits will	

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		& MEDICAID SERVICES	1		OMB NO	APPROVED . 0938-0391
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING _		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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)	JLD BE	(X5) COMPLETION DATE
F 246	that came to above a pair of gripper soc blanket, was observand R19 was noted nostril. On 1/13/16, at 7:29 sitting by the dining dressed with a thin pair of light weight & Resident stated that for breakfast. Registered nurse (F 1/13/16, at 7:38 a.m thin tee shirt on and addition, RN-B conf R19's bed linens an should be changed R19's bed linens an should be changed R19's bed linens sh addition, RN-B conf changed on bath da Monday, 1/11/16. On 1/13/16, at 7:44 were changed every room and saw the b stated, "I will chang clear plastic bag wh as she stripped the NA-G indicated that inserted her finger i content from the no The director of soci 1/13/16, at 12:43 p. appointed guardian	ge 4 the knees. R19 was wearing cks. The top bed linen, a /ed to have small blood stains to be inserting a finger into a a.m. R19 was observed room table. R19 was neatly white tee shirt, no bra and a olue elastic waist band pants. t she was hungry and waiting RN)-B was interviewed on n. and confirmed R19 had a d light weight pants. In firmed the blood spots of nd stated that the bed linens as needed when dirty and nould have been changed. In firmed the resident's linens are ay and R19's bath day was on a.m. NA-G stated bed linens y bath day. NA-G was in R19's blood on the top blanket and e the linens now." NA-G had a nich she put the soiled linen in soiled linen from R19's bed. t the resident frequently nto a nostril and then put the stril on the bed linen. al services (Dir of SS) on m. confirmed R19 had a court , and had no family. The Dir of d R19 did not want to wear a	F 24	46		

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		AND HUMAN SERVICES			FORM	: 03/02/2016 APPROVED
STATEMENT	r of deficiencies of correction	KANNERS KANNERS	. ,	PLE CONSTRUCTION	(X3) DATI	. 0938-0391 E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	•	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 246	Continued From pa	ıge 5	F 246	3		
	A licensed social we clothing in her close 12:57 p.m. The LSV any underwear in h briefs. R19 had app summer blouses ar LSW agreed R19 o clothing in her close call the R19's guard additional clothing f appropriate for the On 1/13/16, at 2:40 had a history of refu- changing clothing a indicated she had s guardian at first wa clothing because sl music therapist for additional considera to the LSW that she to buy R19 winter c The DNS was inter a.m. and indicated would contact the L need of clothing ap weather and then th guardian. R153's quarterly Mi 11/17/15, indicated was always incontin During observation	orker (LSW) reviewed R19's et and dresser on 1/13/16, at W agreed R19 did not have er dresser, only incontinent proximately ten very thin nd ten summer pants. The only had a winter coat for winter et. The LSW stated she would dian and review the need for for R19 that was more winter weather. D p.m., the LSW indicated R19 using showers, personal cares, and wearing a bra. The LSW spoken to R19's guardian. The s reluctant to spend money on he was spending money on a the resident. However, after ation, R19's guardian indicated e would give the facility money				

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) PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA					
		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AME OF F		245148	B. WING			01	/14/2016
	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CO	DE	
OLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA			01 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426		
(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)	HOULD BE	(X5) COMPLETIC DATE
F 246	Continued From pa	•	F 2	46			
		tting in dining room. R153 s that were unzipped leaving					
	the abdomen expos	sed. R153 had a gray and					
		not cover abdomen. R153 had d gray blanket over shoulders.					
		alked by R153 and did not					
	adjust clothing.	alliand by D1EQ and did not					
	adjust clothing.	alked by R153 and did not					
	- 7:55 a.m. a registe	ered dietician adjusted R153's					
	shirt. - 8:01 a.m. R153's breakfast arrived, pancakes						
	with ground sausage. R153 ate the pancakes						
	with fingers. Abdom without adjusting R	en exposed NA-D walked by					
	- 8:13 a.m. R153 sl	eeping at table, abdomen					
		e the umbilicus to under of incontinence brief visible.					
	- 8:16 a.m. NA-E pc	bured milk at R153 s table and					
	did not adjust R153	's clothing.					
		oulled R153's shirt down. The nbilicus but did not cover					
	entire abdomen and						
	immediately.	umbilicus exposed, LPN-B					
	and NA-B walked b	y R153 without adjusting					
	clothing.	divisted D150's slathing					
		adjusted R153's clothing. shirt rolled up to expose					
	abdomen.						
		unfolded blanket and arranged bdomen, chest and shoulders.					
		a.m. R153 was observed					
		room wearing a blue shirt and abdomen was partially					

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		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі			0938-0391 E SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245148	B. WING			01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		14/2010
		LOUIS PARK PLAZA		3	201 VIRGINIA AVENUE SOUTH		
GOLDEN	LIVINGCENTER - 31	LOUIS FARK PLAZA		ę	SAINT LOUIS PARK, MN 55426		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
ind					DEFICIENCY)		
F 246	Continued From pa	ace 7	F 2	246			
		aring a blue shirt and black		. 10			
	pants, abdomen ex	posed up to the umbilicus.					
	Staff in dining room	i passing meais.					
		MDS dated 12/22/15, indicated					
		oderate cognitive impairment					
		assistance with activities of diagnoses included traumatic					
	brain injury and der						
		1/15, at 5:59 p.m. resident was lway with the speech therapist					
	(SLP). R181's shirt	was very loose with a					
		181's abdomen was showing. The resident back from therapy					
	with a hospital gow	n draped over her front upside					
		t stated resident was cold. gown and adjusted the shirt					
	by pulling extra mat	terial behind R181's back, so it					
		and abdomen was not					
	showing. RN-D offe stated, "I thought I v	ered R181 a blanket. R181 was warm."					
		a.m. R181 was observed m. R181 was wearing a brown					
	patterned boat neck	k shirt and a red infinity scarf.					
		was working with R181. t had slipped off right shoulder					
	which exposed R18	31's shoulder exposed. The					
	SLP was still workin	ng with resident. as sitting at the table and the					
	right shoulder was e						
	During an interview	v on 1/14/16, at 11:47 a.m.					
	NA-B said indicated	d R153's clothing did ride up					
		them are too small. We try to d redirect her to larger shirts."					

Facility ID: 00943

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PRINTED: 03/02/2016

		& MEDICAID SERVICES	0.000			0.0938-039	
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		245148	B. WING _		01	/14/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDE	N LIVINGCENTER - ST	LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 246	NA-B was also inte and acknowledged think she has lost w beautiful clothing. V the tops she has we On 1/14/16, at 11:4 director (ACD)-B st larger or smaller clo members were con ACD-B stated the s had clothing that fits know if a resident m family know. If the n I will help the reside the funds, go throug stuff myself. [R153] elastic pants I notic [R153's] guardian a [R181] has a guard designer. She likes being well dressed work with nursing a she has a lot of clot around 30 days. I d clothing on that is to team] IDT meetings weekly and ask do On 1/14/16, at 11:4 her Twins shirt and clothing did ride up too small. NA-B sta and redirect her to director." NA-B ack were too big "I think a lot of beautiful clo	age 8 rviewed about R181's clothing the clothes were too big. "I veight. She has a lot of Ve select the clothing. All of orn today have been too big." 9 a.m. the Alzheimer's care ated if a resident needed othing usually a family tacted to bring clothing. system for ensuring resident s was "I ask staff to let me needs something then I let the resident does not have family, ent purchase stuff if they have gh lost and found or purchase went down yesterday and got ed it yesterday. I will call and follow her guidance. ian. She was a fashion things this way. We know that was important to her. We will assistant to thin out closet so thes. She has been here on't know why we have too big. During [interdisciplinary s we review all residents they need anything." 7 a.m. NA-B stated R153 liked cat shirt. NA-B stated R153 most of time and thought was ted "We try to pull them down larger shirts and have told the nowledged R181's clothes is she has lost weight she has othing. We select the clothing. has worn today have been too	F 24	46			

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		AND HUMAN SERVICES			FORM	03/02/2016 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		.E CONSTRUCTION (E SURVEY PLETED	
		245148	B. WING		01/1	4/2016	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 246	Continued From pa	ge 9	F 246				
F 258 SS=D	clothing but was no 483.15(h)(7) MAIN COMFORTABLE S	OUND LEVELS	F 258			2/23/16	
	by: Based on observat review, the facility f enviroment for 1 of complained of noise Findings include: R48's toilet was rur admission date 11/ ⁷ staff members about noise, no one came now R48 kept the d she would not hear R48's was interview and when asked ab levels, R48 stated t anyone, to come in the toilet in her bath was admitted to the water had been run then. The resident i members (but could when they would co	nning continuously, since her 13/15. R48 had told several ut the running water and the e to fix the running water and loor to her bathroom closed so		 F 258 a. The toilet was repaired at the tim the survey, and the resident express satisfaction with the repair. b. Preventative maintenance progr for bathrooms reviewed and remains current. c. Educate staff to notify maintenar with needed repairs using Building Engines, and educate staff to escala needed repairs to management as identified. d. ED or designee to complete wee audit of 5 bathrooms for toilet in goor repair. Audit results will be reviewed monthly QAPI meeting and the frequot faudits will be changed depending the results of the audits. 	sed am s nce ate ekly d d at J at J at		

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		0938-039 E SURVEY
-	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		3		E SURVEY PLETED
		245148	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETION DATE
F 258 F 278 SS=D	water. The bathroon was running in the t R48's Minimum Dat indicated R48 was of At the beginning of a.m. the director of the noisy toilet and repair request polic 483.20(g) - (j) ASSE ACCURACY/COOF The assessment m resident's status. A registered nurse n each assessment w participation of heal A registered nurse n assessment is com Each individual who assessment must s that portion of the a Under Medicare an willfully and knowing false statement in a subject to a civil mo	m was checked and the water coilet and was very noisy. ta Set dated 11/20/15, cognitively intact. the tour on 1/14/16, at 10:00 maintenance was unaware of was asked for a maintenance y and none was provided. ESSMENT RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate with the appropriate th professionals. must sign and certify that the pleted.	F 25			2/23/16

Facility ID: 00943

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245148	B. WING		01/*	14/2016
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA	STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(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) COMPLETIC DATE
F 278	Clinical disagreeme material and false s This REQUIREMEN by: Based on observat review, the facility fa (R146, R181) Minin coded accurately w and toileting. Findings include: R146's admission N resident was coded for getting to dange was admitted to the hospital with diagno without behavioral of chronic subdural he without foreign body During review of the 10/1/15 through 10/ documentation of re dangerous places a one on one supervis The care plan dated has diagnosis of Ala had cognitive loss, of capabilities and safe had placement in the	Ant does not constitute a statement. AT is not met as evidenced ion, interview, and document ailed to ensure 2 of 3 residents hum Data Set (MDS) was ho was reviewed for accidents MDS dated 10/8/15, indicated as wandering and was at risk rous places. In addition, R146 facility on 10/1/15, from the bess including dementia disturbance, non-traumatic emorrhage and laceration y of scalp. e interdisciplinary notes dated 19/15, revealed no esident wandering to as on most times resident had sion. d 10/2/15, indicated resident cheimer's or related dementia, diminished decision-making ety and security issues and he secure Alzheimer's Care cted staff to allow resident to	F 278	F 278 a. The MDS for R146 was modified reflect accurate wandering status. MDS will be reviewed and modified identified. b. MDS are completed according RAI manual. c. Education of staff responsible completion of sections E. Educat staff responsible for completion of G. All staff education related to be and ADL documentation in the mere record. d. DRA or designee will complet audit of 5 MDS for accuracy of se- for wandering and G for toileting assistance. Audit results will be re- at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the au-	R 181 d as g to the for ion of section ehavior edical e weekly ction E eviewed	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3)	NO. 0938-039 DATE SURVEY	
D PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		COMPLETED	
		245148	B. WING _			01/14/2016	
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
OLDEN	LIVINGCENTER - S	T LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SAINT LOUIS PARK, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE	
F 278	Continued From pa	age 12	F 27	78			
	10/1/15, had been	coded as such and indicated re director (ACD) had					
	completed that sec	tion of the MDS.					
		3 a.m. RN-E reviewed the tes and verified there was no					
	documentation dur	ing the assessment period of					
	resident wandering dangerous places.	around the unit and to					
	-At 8:49 a.m. ACD	verified MDS coding, stated he behavior did put him in a					
	dangerous situatio	n to wander into unsafe areas					
		ay thus coded the MDS as isk to getting to dangerous					
	-At 9:16 a.m. ACD	acknowledged he had coded					
		admission information and he ocumentation completed at the					
	facility. ACD stated	I he had just been hired to his					
		e resident MDS was completed lent MDS was one of the first					
	MDS's he had corr learning.	pleted and was open to					
	Resident Assessm	ong Term Care Facility ent Instrument User's version					
		2015, under the section of ent for Wandering directed					
		dical record and interview staff					
	the 7-day look-bac	ner wandering occurred during k period. Wandering is the act or locomotion in a wheelchair)					
	from place to place	e with or without a specified irection. Wandering may or					
	may not be aimles	s. The wandering resident may or her physical or safety needs.					
		have a purpose such as					

Facility ID: 00943

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		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>				1 APPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245148	B. WING		01	/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	persists without known location of the object behavior may or may thoughts or delusion resident believes sh staff know is decear 2. If wandering occur of the wandering du period." R146's MD wandering. R181 was observed until 8:55 a.m. at 7:1 dining room. R181 room for incontinen a.m. until 8:55 a.m. R181 from wheelch lift. NA-D applied gl pants and opened in area observed to be approximately four or rectum. When NA-ID blanched. The incon saturated with urine saturated with urine saturated with urine R181's admission M resident was coded not occur during the period. In addition, I facility on 12/15/15, diagnoses including disturbance, trauma the MDS. The care plan dated resident was incont	wing the exact direction or ct, person or place. The ay not be driven by confused nal ideas (e.g., when a ne must find her mother, who sed). urred, determine the frequency uring the 7-day look-back S was inaccurately coded for d on 1/13/16, from 7:00 a.m. 00 a.m. R181 was sitting in was then taken back to their ce care on 1/13/16, from 8:46 NA-D and NA-E transferred air to bed using a mechanical oves and removed R181's ncontinence brief. The peri e red from front to centimeter cm above the D touched skin, area ntinent brief was completely e. NA-D verified brief was	F 2	78		

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED
		245148	B. WING _		01	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 278	On 1/13/16, at 2:47 revealed R181 was two hours. On 1/14/16, at 10:4 services stated she	 ⁷ p.m. nursing assistant-B a check and change every 3 a.m. the director of nursing would expect the staff when to be coded accurately and to 	F 27	8		
F 279 SS=D	to code the MDS a toilet room, commo on and off the toilet elimination changes catheter; and adjus bedpan, urinal, bed	s pad; manages ostomy or ts clothes. Do not emptying of side commode, catheter bag, 81's MDS was inaccurately	F 27	9		2/23/16
	to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an	he results of the assessment and revise the resident's n of care. velop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any so	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided				

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TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		0938-039 E SURVEY PLETED	
		045149		J			
NAME OF	PROVIDER OR SUPPLIER	245148		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	14/2016	
		LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 279	due to the resident' §483.10, including i under §483.10(b)(4 This REQUIREMEN by: Based on interview facility failed to dev residents (R187) wi reviewed for unnec Findings include: On 1/14/16, at 12:2 asked about her me knew most of her m did and told survey injections for about when she was preg she was aware of th Lovenox (used to p (DVT) which can le bruising and stated bruised. R187 state administration and the past. Review of R187's D treatment and med did not indicate anti- monitoring including bruising. Review of the Nurs 1/14/16, revealed n addressed even the	s exercise of rights under the right to refuse treatment	F 27	 F 279 a. R 187 care plan was review updated to reflect anticoagulatic b. Audit of all residents care plare on anticoagulation. c. Education of staff responsite plan implementation for anticoag d. DNS or designee completes audit of 5 residents for anticoag care plan in place. Audit results reviewed at monthly QAPI meet the frequency of audits will be c depending on the results of the 	n. ans that le for care gulation. weekly ulation will be ing and nanged		

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CENTER STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTR	UCTION		O. 0938-039	
	F CORRECTION	IDENTIFICATION NUMBER:		NG			COMPLETED	
		245148	B. WING			01/14/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADD	ODE			
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA			NIA AVENUE SOUTH UIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(E/	PROVIDER'S PLAN OF COF ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 279	other venous throm (primary) hypertens history of pulmonar (current) use of ant Electronic Medicati 2015. Review of the care R187 had "Altered related" however potential for bruisin therapy identified/a The Physician Orde R187 had an order (Lovenox) solution mg subcutaneously thromboembolism On 1/14/16, at 12:5 (RN)-C stated usua on a blood thinner the facility had a sta electronic medicatii (EMAR) for the nur stated usually there staff were already s in the EMAR. -At 1:00 p.m. RN-B be" when asked if a be developed wher thinner such as R1 care plan and even	ncluded personal history of abosis and embolism, essential sion, atrial fibrillation, personal ry embolism and long term icoagulants obtained from the on Record dated January plan dated 4/23/15, revealed skin integrity non pressure , did not indicate R187 had the g related to anticoagulation ddressed in the care plan. er dated 10/5/15, indicated for Enoxaparin Sodium milligram/milliliter (mg/ml) 100 y every 12 hours for	F 2	79				
	thromboembolism On 1/14/16, at 12:5 (RN)-C stated usual on a blood thinner s the facility had a sta electronic medicatii (EMAR) for the nur stated usually there staff were already s in the EMAR. -At 1:00 p.m. RN-B be" when asked if a be developed wher thinner such as R1 care plan and even addressed R187 pc bleeding. On 1/14/16, at 2:00	prevention. 66 p.m. registered nurse ally for any resident who was such as Coumadin or Lovenox andard order put in the on administration record ses to check every shift. RN-C e was no care plan for it as the signing off on the side effects approached stated "It should a care plan was supposed to n someone was on a blood 87. RN-B verified the current previous cares plans had not						

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED
		245148	B. WING		01/14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		SAINT LOUIS PARK, MN 55426	
(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) COMPLETIO DATE
F 279	been identified as u Anticoagulant Thera	oped for R187 if resident had ising a blood thinner. apy Guideline last reviewed	F 27	9	
F 282 SS=D	within 24 hours follo anticoagulation then Integrate intervo comprehensive plan interdisciplinary car the policy indicated satisfactory monitor plan of care was to physical observation implemented."	nmediate Plan of Care (IPOC) owing initiation of rapy. entions from IPOC into n of care upon completion of e plan meeting" In addition, for the facility to demonstrate ring/compliance an immediate be individualized and a n showed plan was	F 28	2	2/23/16
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of			
	by: Based on observat review, the facility fa 3 of 4 residents (R1	NT is not met as evidenced ion, interview, and document ailed to follow the care plan for 3, R153, R181) reviewed for ncontinence and for 2 of 3 181) for reviewed		F 282 a. R 13 and R 181 for toileting, and R 153 for toileting and repositioning. Assessments related to alteration in bor and bladder, and repositioning for identified residents will be reviewed and revised as identified.	
	Findings include: Toileting: R13's room was ob	served on 1/14/16, at 7:16		 b. All residents assessments for alteration of bowel and bladder and repositioning will be reviewed at next scheduled care conference. 	

Event ID:76C411

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						. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY	
		245148	B. WING _		01/	/14/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
GOLDEN	I LIVINGCENTER - ST	I LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(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 THE APPROPRIATE	(X5) COMPLETIC DATE	
F 282	a.m. Upon entering smell was noted but the time. At 7:17 a. resident had been day nursing assista assisted the reside a.m. During continu R13 was not toilete change for three ho On 1/14/15, at 10:1 resident had not be over one hour and resident had last be NA-B stated "We a the residents in the transfers because f and some are com the room for half ho another resident in go now. Someone are under staffed a aides with heavy ca even take a 15 min will be lunch here of -At 10:26 a.m. lices stated NA's were s care and were supp timely. LPN-B furth expected NA-B to r late to toilet and res would have attemp she did. R13's urinary Incor Care Area Assessn identified resident w	age 18 g R13's room strong urine ut R13 was not in the room at m. when asked what time assisted to get ready for the ant (NA)-B stated he had nt as R13 had been up at 6:45 uous observation to 10:05 a.m. ed or offered to be checked and ours and 15 minutes. 5 a.m. NA-B acknowledged een toileted timely and was 15 minutes from when een checked and changed. re under staffed and some of a unit need two staff with they use the transfer machine bative and if two aides go into our they is no way I can tell the middle of cares I have to can point a finger at me but we nd for 27 residents for two ares it's impossible. I have not inte break and in 20 minutes coming and I am shaking." sned practical nurse (LPN)-B upposed to follow the plan of posed to toilet the resident er stated she would have report to her he was running sident had refused and she ted to re-approach resident as antinence indwelling catheter nent (CAA) dated 10/14/15, was incontinent of bowel and k for urine body odor, urinary	F 28	32 c. Policy and procedure bowel and bladder, and a reviewed and remains cu to staff on assistance pro planned utilizing care she d. DNS or designee con audit of 5 residents for in repositioning. Audit resu reviewed at monthly QAF the frequency of audits w depending on the results	skin integrity irrent. Education ovided as care eets. mplete weekly continence and lts will be PI meeting and <i>i</i> ll be changed		

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED	
		245148	B. WING _			/14/2016	
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 3201 VIRGINIA AVENUE SOUTH	E		
BOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 282	plan dated 11/13/14 functional incontine Care plan directed sone to toilet. Use br protection and to to and as needed. R13's comprehensi indicated R13 was is bladder and directe every two hours and allowed. R153 was observed until 10:35 a.m. and least three hours. A approached R153 if and asked R153 if be changed. (NA-E "No." At 10:19 a.m. after asking permiss NA-D transferred R with mechanical lift. urine present when registered nurse (R the urine odor. NA-I gloves, and remove removed R153's ind was saturated with brief was saturated. with an incontinence on incontinence wip area from back to fr incontinence brief. The Alteration in Eli	A, identified resident had a nce of bladder and bowel. staff to provide assistance of iefs/pads for incontinence illet resident every two hours we assessment dated 1/4/16, ncontinent of bowel and d staff to check and assist d as needed as resident d on 1/13/16, from 7:00 a.m. I R153 was not toileted for at t 10:09 a.m. NA-E n day room during activities would like to go to room and asked quietly) R153 said, NA-B brought R153 to room sion. At 10:25 a.m. NA-B and 153 from wheel chair to bed There was a strong odor of R153 was lying in bed. N)-D was present and verified B washed hands, put on d R153's pants. NA-B continence brief. The product urine and RN-D verified the NA-D wiped R153's bottom e wipe. Brown stool observed be. NA-D washed R153's peri ront, then applied new	F 28	32			

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DEPAR		APPROVED						
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	. 			OMB NO. 0938-0391		
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(-)	E SURVEY PLETED	
		245148	B. WING	i		01/	14/2016	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA					3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ige 20	F 2	282	2			
	physical functioning impairment, and me goals were that R15 odor free. Care plan required extensive personal hygiene, b indicated R153 had ADL assistance dep The undated nursin for R153 instructed incontinent of bowe checked and chang R181 was observed until 8:55 a.m. at 7: dining room. R181 patterned boat neck During observation 1/13/16, from 8:46 a NA-E transferred R using a mechanical removed R181's pa brief. The peri area to approximately for rectum. When NA-I blanched. The inco saturated with urine saturated with urine saturated with urine saturated with urine	ng assistant assignment sheet staff that R153 was el and bladder and was to be ge every two hours. d on 1/13/16, from 7:00 a.m. 00 a.m. R181 was sitting in was wearing a brown k shirt and a red infinity scarf. of incontinence care on a.m. until 8:55 a.m. NA-D and 181 from wheelchair to bed 181 from wheelchair to bed 181 from wheelchair to bed 1 lift. NA-D applied gloves and ants and opened incontinence observed to be red from front ur centimeter cm above the D touched skin, area ntinent brief was completely e. NA-D verified brief was e. nt dated 12/22/15, indicated al urinary incontinence and was toileting or retraining program						

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PRINTED: 03/02/2016

		& MEDICAID SERVICES	1				. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IULTIPLE CONSTRUCTION		· · ·	TE SURVEY MPLETED	
		245148	B. WING _			01/14/2016		
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426					
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 282	was functionally inc	ge 21 ontinent of bowel and bladder. check and change R181	F 2	82				
	every two and as ne							
	R181 instructed sta	ssistant assignment sheet for Iff that R181 was incontinent ked and change every two ed.						
	said, "[R153] was o started at about 6:4 7:00 a.m. [R153] wa	1/13/16, at 9:49 a.m. NA-B ur third resident to get up. We 5 a.m. and were done about as taken for activities and had refused that morning. [R181]						
	[R181] is laid down then at 11 a.m. The two hours for chang does not refuse toil							
	repositioned every t change every two h be changed. LPN-E	B said R153 was to be two hours and check and ours. R153 could also ask to acknowledged R153 had not er two hours. LPN-B stated						
	LPN-B would have away. R181 was to two hours.	someone take care of it right be checked and change every E stated we got R153 up						
		D stated R153 was to be two hours and offered to be hours						
	- At 2:47 p.m. NA-B NA-B stated, "Right When asked about	B stated was working a double. t now we are short staffed." assisting residents to the						
	cannot always do th repositioning and cl	e repositioned NA-B said, "You ne every two hours turning and hanging because you need n it takes you 15 to 30 minutes						

Facility ID: 00943

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		AND HUMAN SERVICES				FORM	: 03/02/2016 APPROVED . 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245148	B. WING			01/14/2016		
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ae 22	F 2	282				
	and you need to do	the next one. How can you fix						
	to do the reposition hours. We are so b best." NA-D said, "I to back, but I wiped front. I am not sure - At 9:22 a.m. the d (DNS) said, "I expe regarding incontine check and change their care plans." R provided incontiner of care. Repositioning: R153 was observed until 10:35 a.m. for - At 7:00 a.m. R153 mechanical lift sling - At 9:05 a.m. R153 sleeping at table, pr a.m. - At 9:30 a.m. Alzhe wheeled R153 to da - At 9:49 a.m. R153 - At 10:09 a.m. NA- room during activiti like to go to room a quietly) R153 said, - At 10:19 a.m. NA- asking permission. - At 10:25 a.m. R153 area to the coccyx. immediately above The coccyx had an (cm.) x 1.5 cm non	B sitting in dining room. A g under R153. B sitting in dining room, osition unchanged since 7:00 eimer's care director-B ay room. B sitting in activity room. E approached R153 in day es and asked R153 if would nd be changed. (NA-E asked						

If continuation sheet Page 23 of 84

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE	E SURVEY PLETED
		245148	B. WING	i		01 / [.]	14/2016
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOLDEN	N LIVINGCENTER - ST	LOUIS PARK PLAZA			3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	not blanchable. The Pressure Ulcer "CAA triggered for p CVA [stroke] with we requires staff assist see MDS ADL/conti is at risk for pressured decline." The care plan revise ulcer present to right tissue injury. Ulceral Interventions includd resident was in bedt that are stationary in therapy, float heels hours. R181 was observed until 8:55 a.m. for re- - At 7:00 a.m. R181 Mechanical lift sling - At 7:45 a.m. NA-B R181 - At 7:56 a.m. break and NA-B started to - At 8:10 a.m. speed at the dining room t - At 8:46 a.m. NA-D room and took to roo transferred R181 for mechanical lift. The red from front to ap cm above the rectu	r CAA dated 6/26/15, indicated pressure r/t Hx [history of] of yeakness, res. is incontinent, tance with bed mobility/cares, inence coding. Res. [resident] re, infection, pain and overall ed 1/12/16, indicated pressure ht heel - suspected deep ation to left lateral malleolus. ded heel boots to be worn while and had specialized boots in wheelchair, provided by while in bed, offload every two d on 1/13/16, from 7:00 a.m. epositioning. I was sitting in dining room. g under R181. B sat down and talked with kfast was delivered to R181 o feed R181. och therapy working with R181	F 2	282			

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PRINTED: 03/02/2016

		AND HUMAN SERVICES				FORM	: 03/02/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245148	B. WING			01	/14/2016
NAME OF	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Urinary incontinence indicated "CAA trigg incontinence. Res [break down, UTI. P staff aware and pro Update MD [medica practitioner] PRN." The plan off care in to turn and reposition During interview on said R153 was the started at about 6:4 7:00 a.m. [R153] was been asked or refus our first resident to laid down and char a.m. Then 1:00 p.m changing and repose refuse toileting." - At 9:56 a.m. LPN- repositioned every acknowledged R18 two hours. - At 10:11 a.m. NA- around 6:30 a.m." - At 10:13 a.m. RN- repositioned every there would be skir potential deep vein contractures." RN-I repositioned every there would be skir potential deep vein contractures." - At 2:47 p.m. NA-E double. NA-B state	e CAA dated 12/24/15, gered dr/t [sic- d/t due to] urine resident] is at risk for skin proceed to care plan to ensure ovide care PRN [as needed]. al doctor] NP [nurse hitiated on 1/6/16, directed staff on R181 every two hours. 1/13/16, at 9:49 a.m. NA-B third resident to get up. "We 5 a.m. and were done about as taken for activities, has not sed this morning. [R181] was get up at 6:10 a.m. [R181] is nged after breakfast then at 11 n. [R181] is every two hours for sitioning. [R181] does not B said (R153) was to be	F2	282			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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) COMPLETIO DATE
F 282 F 312 SS=D	be repositioned NA do the every two ho and changing beca then it takes you 15 to do the next one. - At 2:55 p.m. NA-E time to do the report two hours. We are best." The undated Golde integrity Guideline i every two hours, or taking into consider tolerance and choic condition of skin. If individualized plan be implemented, even the needs of the re- 483.25(a)(3) ADL C DEPENDENT RES A resident who is u daily living receives maintain good nutri and oral hygiene. This REQUIREMEN	-B said, "You cannot always purs turning and repositioning use you need two people and to 30 minutes and you need How can you fix it?" Said, "I don't always have sitioning and toileting every so busy right now. We do our on Clinical Services Skin nstructed staff to "reposition as needed and tolerated, ration patient/resident be, tissue tolerance, current ndicate frequency in the of care" and "Care plan is to valuated and revised based on sident." CARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal	F 282	F 312		2/23/16
	Based on observative review, the facility f assistance with act	tion, interview, and document ailed to provide timely ivities of daily living (ADLs) for 53) who was incontinent of		 F 312 a. R 153 assessment relating to alteration of bowel and bladder wireviewed and revised. b. All residents assessments for alteration of bowel and bladder wireviewed at next scheduled care 	ll be	

Event ID:76C411

Facility ID: 00943

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED
		245148	B. WING _		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 312	Continued From pa	ge 26	F 31	2		
	until 10:35 a.m. and least three hours. A (NA)-E approached activities and asked room and be chang R153 said, "No." At R153 to room after a.m. NA-B and NA- wheel chair to bed v a strong odor of unil lying in bed. Registe present and verified hands, put on glove NA-B removed R15 product was saturative verified the brief wa R153's bottom with stool observed on in washed R153's per applied new incontil Bladder assessmen 11/17/15, indicated for bowel and bladd diagnosis of dement cerebrovascular dis every 2 hours and a The Urinary Incontil (CAA) dated 6/26/1 for incontinence r/t incontinent of bowe ADL/continence coo [urinary tract infection	nt dated 6/15/15 and reviewed resident was not appropriate ler retraining program due to tia, psychosis and unspecified sease. Staff was to toilet R153 as needed. nence Care Area Assessment 5, indicated, "CAA triggered [related to] res. [resident] is I and bladder, see MDs ding. Res. is at risk for UTI on], Skin CAA triggered for . is at risk for UTI, skin		 conference. c. Policy and procedure for all bowel and bladder reviewed an current. Education to staff on a provided as care planned utilizin sheets. d. DNS or designee complete audit of 5 residents for incontine Audit results will be reviewed at QAPI meeting and the frequence will be changed depending on t of the audits. 	d remains assistance ng care weekly ence. monthly cy of audits	

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		AND HUMAN SERVICES & MEDICAID SERVICES					M APPROVED 0. 0938-0391
-	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			ATE SURVEY OMPLETED
		245148	B. WING			0	1/14/2016
NAME OF	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP C	ODE	
GOLDEN	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA A	AVENUE SOUTH PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	(EACH C	VIDER'S PLAN OF COF CORRECTIVE ACTION EFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 312	The Alteration in Eli Bladder, Incontinen plan dated 6/29/15, change resident ever Care plan dated 11/ physical functioning impairment, and mo goals were that R15 odor free. Care plar required extensive a personal hygiene, b indicated R153 had ADL assistance dep The undated Nursin for R153 instructed incontinent of bowe checked and chang During interview on said, "[R153] was o started at about 6:4 7:00 a.m. [R153] was o started at about 6:4 7:00 a.m. [R153] was not been asked or r - At 9:56 a.m. licens said R153 was to be and check and chan could also ask to be acknowledged R15: two hours. LPN-B s someone take care - At 10:11 a.m. NA- around 6:30 a.m. - At 10:13 a.m. RN- repositioned every two - At 2:47 p.m. NA-B	mination of Bowel and ce of bowel and bladder care instructed staff to check and ery two hours and as needed. (18/15, indicated R153 had a deficit related to self-care obility impairment. Care plan 53 would be clean, dry, and n instructed staff that R153 assist of one for dressing, iathing, and toileting. It also a history of refusing some bending on mood. In gAssistant Assignment Sheet staff that R153 was I and bladder and was to be e every two hours. 1/13/16, at 9:49 a.m. NA-B ur third resident to get up. We 5 a.m. and were done about as taken for activities and had efused that morning. Sed practical nurse (LPN)-B e repositioned every two hours nge every two hours. R153 e changed. LPN-B 3 had not been toileted in over tated LPN-B would have of it right away. E stated we got R153 up D stated R153 was to be two hours and offered to be	F 3	12			

Facility ID: 00943

If continuation sheet Page 28 of 84

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	СОМ	PLETED
		245148	B. WING _		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 312	When asked about bathroom and to be cannot always do the repositioning and cl two people and the and you need to do it?" - At 2:55 p.m. NA-E time to do the repose two hours. We are best." NA-D said, "I to back, but I wiped front. I am not sure - At 9:22 a.m. the d said, "I expect the se regarding incontine check and change their care plans." R incontinent cares are	assisting residents to the e repositioned NA-B said, "You he every two hours turning and hanging because you need n it takes you 15 to 30 minutes the next one. How can you fix 0 said, "I don't always have sitioning and toileting every so busy right now. We do our know I am to wipe from front I both of them from back to why. They could get sick." irector of nursing services staff to follow our policy nce care I expect them to residents in accordance to 153 was not provided ccording to the plan of care.	F 3 ⁻			
	Facility procedure I Management/Blado effective date 1/19/ bladder manageme urinary incontinence as normal bladder f The section "Choos Resident After Eval resident is unsucce unable to participat resident should be program. Absorben collection devices v policy in conjunction Changing programs incontinence." The	nt requested but not provided. ncontinence der Function Guideline 15, Indicated the purpose of a ent program is to:"Manage e, restore or maintain as much function as possible." sing A Program That Fits The uation:" instructed staff, "If essful at toilet training or is e in retraining than the placed on incontinence care it products and external will be used as per center n with incontinence care. s are also driven by patterns of facility provided procedure regarding the development of				

Facility ID: 00943

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING _		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312		ge 29 ion to nursing assistants on	F 31	2		
F 314 SS=D	483.25(c) TREATM PREVENT/HEAL P		F 31	4		2/23/16
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece	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 e healing, prevent infection and from developing.				
	by: Based on observat review, the facility fa repositioning to 2 of reviewed for potent Findings include: R153 was observed until 10:35 a.m. for - At 7:00 a.m. R153 mechanical lift sling - At 9:05 a.m. R153 sleeping at table, po a.m. - At 9:30 a.m. Alzhe wheeled R153 to da - At 9:49 a.m. R153 - At 10:09 a.m. nurs approached R153 in	d on 1/13/16, from 7:00 a.m. repositioning. s sitting in dining room. A under R153. s sitting in dining room, osition unchanged since 7:00 simer's care director-B		 F 314 a. R 153 and R 181 for reposit Assessments related to repositi cited residents will be reviewed revised as identified. b. All residents assessments fi integrity will be reviewed at next scheduled care conference. c. Policy and procedure for sk and skin integrity reviewed and current. Education to staff on a provided as care planned utilizin sheets. d. DNS or designee complete audit of 5 residents for repositio Audit results will be reviewed at QAPI meeting and the frequence will be changed depending on th of the audits. 	oning for and or skin in integrity, remains issistance ing care weekly ning. monthly y of audits	

Facility ID: 00943

If continuation sheet Page 30 of 84

		AND HUMAN SERVICES				FORM	: 03/02/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245148	B. WING			01/	14/2016
		LOUIS PARK PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH	•	
GOLDEN	EIVINGCENTER - 3			Ś	SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 30	F3	314	1		
	•	asked quietly) R153 said,					
	- At 10:19 a.m. NA- asking permission. - At 10:25 a.m. R15 area to the coccyx. immediately above The coccyx had an (cm.) x 1.5 cm non Registered nurse (I verified the coccyx The Pressure Ulce (CAA) dated 6/26/1 pressure r/t [related [stroke] with weakn requires staff assis see MDS [Minimun daily living]/contine	B brought R153 to room after 53's bottom was red from peri The area from peri area to the rectum was blanchable. approximately 4 centimeter blanchable red area. RN)-D was present and was red and not blanchable. r Care Area Assessment 5, indicated "CAA triggered for d to] Hx [history of] of CVA less, res. is incontinent, tance with bed mobility/cares, n Data Set] ADL[activities of nce coding. Res. [resident] is , infection, pain and overall					
	9/22/15, indicated F and left heels and a	re Skin Assessment dated 153 had a current ulcer right a history of pressure ulcer on n indicated reposition every					
	resident was cognit assistance with AD incontinent of bowe	DS dated 11/17/15, indicated tively intact, required Ls, and was always and bladder. R153's parterly MDS included stroke, ad disorder.					
	ulcer present to rig tissue injury. Ulcera	ed 1/12/16, indicated pressure ht heel - suspected deep ation to left lateral malleolus. led heel boots to be worn while					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/02/2016 APPROVED : 0938-0391
STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245148	B. WING _		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEI	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	resident was in bed that are stationary in therapy, float heels every two hours. The undated Nursin for R153 instructed repositioning sched of two with off loadi sling and mechanic on feet while in be a R181 was observed until 8:55 a.m. for re- At 7:00 a.m. R181 Mechanical lift sling - At 7:45 a.m. NA-B R181 - At 7:56 a.m. break and NA-B started to - At 8:10 a.m. speed at the dining room t - At 8:46 a.m. NA-D room and took to root transferred R181 from mechanical lift. The red from front to ap cm above the rectu area blanched. NA- boots on. Urinary Incontinenc indicated "CAA trigg incontinence. Res is UTI [urinary tract in to ensure staff awat	and had specialized boots n wheelchair, provided by while in bed, and offload ng Assistant Assignment Sheet staff that R153 turning and ule was R153 required assist ng and transfers using a large al lift. R153 was to have boots and in wheel chair. d on 1/13/16, from 7:00 a.m. epositioning. was sitting in dining room. under R181. s at down and talked with afast was delivered to R181 o feed R181. ch therapy working with R181 able. pulled R181 out of dining bom. NA-D and NA-E om wheelchair to bed using a peri area was observed to be proximately four centimeter m. When NA-D touched skin, D put R181's pants and blue e CAA dated 12/24/15,	F 3			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245148	B. WING			01/ [.]	14/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
		LOUIS PARK PLAZA		32	201 VIRGINIA AVENUE SOUTH		
GOLDEN	I LIVINGCENTER - 31	LOUIS FARK FLAZA		S	AINT LOUIS PARK, MN 55426		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 32	F 3	14			
		itiated on 1/6/16, directed staff on R181 every two hours.					
	said R153 was the started at about 6:4 7:00 a.m. [R153] was been asked or refus our first resident to laid down and chan a.m. Then 1:00 p.m changing and repose refuse toileting." - At 9:56 a.m. LPN- repositioned every fa acknowledged R18 two hours. - At 10:11 a.m. NA- around 6:30 a.m." - At 10:13 a.m. RN- repositioned every fa there would be skin potential deep vein contractures." RN-E repositioned every fa there would be skin potential deep vein contractures." RN-E repositioned every fa there would be skin potential deep vein contractures." - At 2:47 p.m. NA-E double. NA-B stated staffed." When ask be repositioned NA do the every two ho and changing beca then it takes you 15 to do the next one. - At 2:55 p.m. NA-E	1/13/16, at 9:49 a.m. NA-B third resident to get up. "We 5 a.m. and were done about as taken for activities, has not sed this morning. [R181] was get up at 6:10 a.m. [R181] is ged after breakfast then at 11 a. [R181] is every two hours for sitioning. [R181] does not B said (R153) was to be two hours. LPN-B 1 was to be repositioned every E stated, "We got [R153] up D stated R153 was to be two hours. "If it does not occur issues, skin breakdown thrombosis (clots) or D stated R181 was to be two hours. "If it does not occur issues, skin breakdown thrombosis (clots) or D stated R181 was to be two hours. "If it does not occur issues, skin breakdown thrombosis (clots) or D stated R181 was to be two hours. "If it does not occur issues, skin breakdown thrombosis (clots) or D stated R181 was to be two hours. "If it does not occur issues, skin breakdown thrombosis (clots) or B stated they were working a d, "Right now we are short ed about assisting residents to -B said, "You cannot always purs turning and repositioning use you need two people and to 30 minutes and you need How can you fix it?" D said, "I don't always have sitioning and toileting every					

If continuation sheet Page 33 of 84

		AND HUMAN SERVICES		F	TED: 03/02/2016 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		245148	B. WING		01/14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 314	Continued From pa	ge 33	F 314	1	
	two hours. We are best."	so busy right now. We do our			
F 315 SS=D	integrity Guideline i every two hours, or taking into consider tolerance and choic condition of skin. In individualized plan be implemented, ev the needs of the res 483.25(d) NO CATH RESTORE BLADD	HETER, PREVENT UTI,	F 315	5	2/23/16
	assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder			
	by: Based on observat review, the facility f assistance with incorresidents (R13, R13 incontinence. Findings include:	NT is not met as evidenced tion, interview, and document ailed to provide timely pontinence care for 3 of 4 53, R181) reviewed for urinary p.m. during room observation		F 315 a. R 13 and R 153 and R 181 assessment relating to alteration of b and bladder will be reviewed and revi b. All residents assessments for alteration of bowel and bladder will be reviewed at next scheduled care conference. c. Policy and procedure for alteratio	sed.

Event ID:76C411

Facility ID: 00943

If continuation sheet Page 34 of 84

245148 245148 IS PARK PLAZA IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	A. BUILDIN	IPLE CONSTRUCTION IG STREET ADDRESS, CITY, STATE, ZIP C 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ODE RRECTION SHOULD BE	E SURVEY PLETED 14/2016 (X5) COMPLETIC DATE
IS PARK PLAZA	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP C 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ODE RRECTION SHOULD BE	(X5) COMPLETIO
NT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	PREFIX TAG	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	RRECTION SHOULD BE	COMPLETIC
NT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	PREFIX TAG	SAINT LOUIS PARK, MN 55426 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	RECTION SHOULD BE	COMPLETIC
BE PRECEDED BY FULL NTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
	F 31			
have a musty urine		5		
		bowel and bladder reviewed current. Education to staff provided as care planned ut	on assistance	
during a subsequent smell of air fresher was masked the urine smell.		audit of 5 residents for incor	ntinence.	
upon entering R13's was noted but R13 was ne. At 7:17 a.m. when t had been assisted to		QAPI meeting and the frequ	iency of audits	
sing assistant (NA)-B a.m. when approached ing to surveyor but was				
ng room table for {13 was observed seated				
(LPN)-B was wheeled the television (TV)				
wandering, appeared 29 a.m. NA-B was				
n. At 9:33 a.m. NA-B and ent. Then NA-B handed a esident to read and				
d then both staff wheeled m. When NA-B was se the grab bar resident				
IA-B. Both NA's were suade resident but en wheeled R13 out of				
om and NA-B indicated to toilet R13 in 15 tion both NA's never				
	masked the urine smell. upon entering R13's was noted but R13 was ie. At 7:17 a.m. when t had been assisted to sing assistant (NA)-B a.m. when approached ing to surveyor but was At 7:51 a.m. to 9:12 a.m. ng room table for R13 was observed seated er room. At 9:20 a.m. (LPN)-B was wheeled the television (TV) 8 was observed wheeling wandering, appeared 9 a.m. NA-B was and wheeled resident n. At 9:33 a.m. NA-B and ent. Then NA-B handed a esident to read and d then both staff wheeled m. When NA-B was se the grab bar resident IA-B. Both NA's were suade resident but en wheeled R13 out of om and NA-B indicated to toilet R13 in 15	smell of air fresher was masked the urine smell. upon entering R13's was noted but R13 was ie. At 7:17 a.m. when t had been assisted to sing assistant (NA)-B a.m. when approached ing to surveyor but was At 7:51 a.m. to 9:12 a.m. ng room table for R13 was observed seated er room. At 9:20 a.m. (LPN)-B was wheeled the television (TV) 8 was observed wheeling wandering, appeared 99 a.m. NA-B was and wheeled resident in. At 9:33 a.m. NA-B and ont. Then NA-B handed a esident to read and d then both staff wheeled m. When NA-B was se the grab bar resident IA-B. Both NA's were suade resident but en wheeled R13 out of om and NA-B indicated to toilet R13 in 15 tion both NA's never inge R13 which was two	during a subsequent smell of air fresher was masked the urine smell. upon entering R13's was noted but R13 was te. At 7:17 a.m. when t had been assisted to sing assistant (NA)-B a.m. when approached ing to surveyor but was At 7:51 a.m. to 9:12 a.m. ng room table for t13 was observed seated or room. At 9:20 a.m. (LPN)-B was wheeled the television (TV) a was observed wheeling wandering, appeared 9 a.m. NA-B was and wheeled resident n. At 9:33 a.m. NA-B and int. Then NA-B handed a esident to read and d then both staff wheeled m. When NA-B was se the grab bar resident IA-B. Both NA's were suade resident but en wheeled R13 out of om and NA-B indicated to toilet R13 in 15 tion both NA's never inge R13 which was two	during a subsequent smell of air fresher was masked the urine smell. upon entering R13's was noted but R13 was te. At 7:17 a.m. when thad been assisted to sing assistant (NA)-B a.m. when approached ing to surveyor but was At 7:51 a.m. to 9:12 a.m. ng room table for 113 was observed seated rr room. At 9:20 a.m. (LPN)-B was wheeled the television (TV) was observed wheeling wandering, appeared 99 a.m. NA-B was and wheeled resident n. At 9:33 a.m. NA-B and ent. Then NA-B handed a assident to read and d then both staff wheeled m. When NA-B was see the grab bar resident IA-B. Both NA's were suade resident but en wheeled R13 out of or mand NA-B indicated to toilet R13 in 15 tion both NA's never nge R13 which was two

Facility ID: 00943

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE CO	ONSTRUCTION		TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		CO	MPLETED
		245148	B. WING _				/14/2016
NAME OF I	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	E	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			VIRGINIA AVENUE SOUTH IT LOUIS PARK, MN 55426		
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 315	Continued From pa	-	F 3 ⁻	15			
		9:37 a.m. when approached a					
a.m. R13 was		was noted on resident. At 9:40 erved self transfer to a regular					
		nge. At 9:44 a.m. R13 again					
		o the wheelchair then was					
	nursing station.	down the hallway towards the					
	-At 9:47 a.m. R13 v	was observed seated on					
		from the nursing station. yor approached LPN-B					
	requested to have r						
	-At 9:56 a.m. both I	LPN-B and NA-B went to room					
		sident stand in the toilet but tempting to grab on male staff					
	-At 10:04 a.m. LPN	I-B finally suggested to lay					
		ed to change resident which					
	was 3 hours and ar	I-B and NA-B assisted resident					
	to bed and as resid	lent stood up LPN-B stated					
		3's pants and incontinent pad					
		ked with urine. At 10:13 a.m.					
	"it's a little bit wet."						
	resident had not be	5 a.m. NA-B acknowledged en toileted timely and was					
		15 minutes from when een checked and changed.					
		re under staffed and some of					
		unit need two staff with					
		they use the transfer machine bative and if two aides go into					
		our they is no way I can tell					
	another resident in	the middle of cares I have to					
		can point a finger at me but we nd for 27 residents for two					
	aides with heavy ca	ares it's impossible. I have not					
	even take a 15 min	ute break and in 20 minutes					

Facility ID: 00943

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		TE SURVEY MPLETED
		245148	B. WING _		01	/14/2016
-				STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH	1	
OLDEN	I LIVINGCENTER - ST			SAINT LOUIS PARK, MN 55426		
(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 SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 315	will be lunch here c -At 10:26 a.m. LPN follow the plan of ca toilet the resident tin would have expected was running late to refused and she wo re-approach residen R13's diagnoses ind disorder, unspecifie infarction without re osteoarthritis, unsp behavioral disturbat obtained from the a 1/14/16. R13's Urinary Incor Care Area Assessm identified resident w bladder, was at risk tract infections and plan dated 11/13/14 functional incontine Care plan directed one to toilet. Use br protection and to to and as needed. R13's comprehensi indicated R13 was bladder and directe	oming and am shaking." stated NA's were supposed to are and were supposed to mely. LPN-B further stated she ed NA-B to report to her he toilet and resident had build have attempted to	F 3	15		

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		AND HUMAN SERVICES			FORM	: 03/02/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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) COMPLETION DATE
F 315	R153 was observed until 10:35 a.m. and least three hours. A approached R153 if and asked R153 if y be changed. (NA-E "No." At 10:19 a.m. after asking permis NA-D transferred R with mechanical lift. urine present when registered nurse (R the urine odor. NA- gloves, and remove removed R153's ind was saturated with brief was saturated with an incontinence on incontinence brief. Bladder assessmer 11/17/15, indicated for bowel and bladd diagnosis of demen cerebrovascular dis every two hours and The Urinary Incontin indicated, "CAA trig [related to] res. [res and bladder, see M ADL [activities of da Res. is at risk for U CAA triggered for in for UTI, skin breakd	d on 1/13/16, from 7:00 a.m. d R153 was not toileted for at tt 10:09 a.m. NA-E n day room during activities would like to go to room and asked quietly) R153 said, NA-B brought R153 to room sion. At 10:25 a.m. NA-B and 153 from wheel chair to bed . There was a strong odor of R153 was lying in bed. N)-D was present and verified B washed hands, put on ed R153's pants. NA-B continence brief. The product urine and RN-D verified the . NA-D wiped R153's bottom e wipe. Brown stool observed be. NA-D washed R153's peri ront, then applied new	F 315			

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	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245148	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CC		/14/2016		
	PROVIDER OR SUPPLIER	T LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY 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) COMPLETIC DATE		
F 315	plan dated 6/29/15 change resident er R153's quarterly M resident was cogn assistance with AE incontinent of bow diagnoses listed q psychosis and mo Care plan dated 1 [°] physical functionin impairment, and m goals were that R1 odor free. Care pla required extensive personal hygiene, indicated R153 ha ADL assistance de The undated Nurs for R153 instructed incontinent of bow checked and chan R181 was observe until 8:55 a.m. at 7 dining room. R181 for incontinence ca	nce of bowel and bladder care 5, instructed staff to check and very two hours and as needed. MDS dated 11/17/15, indicated itively intact, required DLs, and was always el and bladder. R153's uarterly MDS included Stroke,	F 3'	15				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/02/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245148	B. WING			01/	14/2016	
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA		3	STREET ADDRESS, CITY, STATE, ZIP CODE 201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426	•		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 315	urine. NA-D verified urine. The Bladder Assess indicated R181 had incontinence and w or retraining progra immobility. R181's admission I resident was mode required assistance incontinent of bladd of stool. R181's dia brain injury and der Urinary Incontinence indicated "CAA trig incontinence. Res UTI. Proceed to ca and provide care P [medical doctor] NF The care plan date was functionally ind It instructed staff to every two and as n the undated Nursin for R181 instructed incontinent and wa every two hours an During interview or said, "[R153] was o started at about 6:4 7:00 a.m. [R153] w	d brief was saturated with sment dated 12/22/15, d functional urinary vas not appropriate for toileting im because of dementia and MDS dated 12/22/15, indicated rately impaired cognitively, e with ADLs, and was always der and frequently incontinent ignoses included traumatic mentia. ce CAA dated 12/24/15, gered dr/t [sic] urine is at risk for skin break down, re plan to ensure staff aware RN [as needed]. Update MD P [nurse practioner] PRN." d 1/12/16, indicated resident continent of bowel and bladder. o check and change R181 eeded. g Assistant Assignment Sheet I staff that R181 was s to be checked and change	F	315				

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		AND HUMAN SERVICES				FORM	03/02/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY PLETED
		245148	B. WING	i		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 315	[R181] is laid down then at 11 a.m. The two hours for chang does not refuse toil - At 9:56 a.m. LPN- repositioned every to change every two h be changed. LPN-B been toileted in ove LPN-B would have away. R181 was to two hours. - At 10:11 a.m. NA- around 6:30 a.m. - At 10:13 a.m. RN- repositioned every two - At 2:47 p.m. NA-B NA-B stated, "Right When asked about bathroom and to be cannot always do th repositioning and cl two people and the and you need to do it?" - At 2:55 p.m. NA-D to do the reposition hours. We are so b best." NA-D said, "I to back, but I wiped front. I am not sure - At 9:22 a.m. the d said, "I expect the s regarding incontine check and change	and changed after breakfast en at 1:00 p.m. [R181] is every ging and repositioning. [R181] eting." B said R153 was to be two hours and check and nours. R153 could also ask to acknowledged R153 had not er two hours. LPN-B stated someone take care of it right be checked and change every E stated we got R153 up D stated R153 was to be two hours and offered to be hours. B stated was working a double. t now we are short staffed." assisting residents to the e repositioned NA-B said, "You he every two hours turning and hanging because you need n it takes you 15 to 30 minutes the next one. How can you fix D said "I don't always have time ing and toileting every two usy right now. We do our know I am to wipe from front both of them from back to why. They could get sick." lirector of nursing services staff to follow our policy nce care I expect them to residents in accordance to 153 and R181 was not	F 3	315			

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		AND HUMAN SERVICES				FORM	: 03/02/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245148	B. WING			01/	/14/2016
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA	STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	effective date 1/19/ bladder manageme urinary incontinence as normal bladder in The section "Choose Resident After Eval resident is unsucce unable to participat resident should be program. Absorber collection devices w policy in conjunctio Changing programs incontinence." The undated Golder integrity Guideline i every two hours, or taking into consider tolerance and choic condition of skin. If individualized plan be implemented, ev the needs of the re- 483.25(h) FREE OF HAZARDS/SUPER The facility must er environment remain as is possible; and	ncontinence der Function Guideline (15, Indicated the purpose of a ent program is to:" Manage e, restore or maintain as much function as possible". sing A Program That Fits The luation: "Instructs staff If essful at toilet training or is e in retraining than the placed on incontinence care at products and external will be used as per center n with incontinence care. s are also driven by patterns of en Clinical Services Skin nstructed staff to "reposition as needed and tolerated, ration patient/resident ce, tissue tolerance, current ndicate frequency in the of care" and "Care plan is to valuated and revised based on sident." F ACCIDENT	F 3				2/23/16

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		AND HUMAN SERVICES				FORM	03/02/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245148	B. WING			01/ ⁻	14/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	by: Based on observat review, the facility f were free of splinte (2N had 29 residen residents which cou and visitors on the environment in roor electrical cords in re potential to cause a Findings include: During a tour of the a.m. through 11:00 (DM), administrator director of environn and laundry) the fol concern: - Handrails outside splintered and had - Rooms 240 B and personal items, clui - Room 383B had a cords near an outle had the potential to The facility's policy 11/18/15, indicated difficulty in either co possessions becau save them to the potential - review health and if able to understan	NT is not met as evidenced tion, interview, and document ailed to maintain handrails that rs on outside of rooms 207 ts) and 232 (2S had 30 uld have been affected), staff, units, a clutter free m 240B and 268B, and tangled oom 383B and had the accidents. e facility on 1/14/16, at 10:00 a.m. with the district manager r, director of maintenance, and nental services (housekeeping llowing areas were a safety of rooms 207 and 232 were sharp wooden edges d 268 B had a huge amount of tter, in boxes in disarray a numerous black electrical et that looked like spaghetti and cause an accident or injury. on Hoarding, effective date "Hoarding is a persistent bllecting or parting with ise of a perceived need to bint of creating distress."		823	F 323 a. Handrails on 2nd floor will be inspected and repaired for splinter Rooms 240b and 268b will be assis pack up belonging and rearrange for clutter free. Room 383b cords hav arranged for safety. b. Preventative maintenance prog place for identification and repair of and accident concerns. The ED or designee is responsible to complet routine environmental rounds to ide safety and accident concerns. c. Education to staff on identificat accident and safety concerns and notification to maintenance or management to address safety and accident hazards related to handra cords, and clutter in rooms. d. ED or designee to complete we audits of 1 unit and 5 rooms for har splinter free and rooms free of clutt cords. Audit results will be reviewed monthly QAPI meeting and the free of audits will be changed depending the results of the audits.	e been gram in safety e been gram in safety e bentify ion of d ils, beekly ndrails er and d at guency	

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		AND HUMAN SERVICES				FORM	03/02/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245148	B. WING			01/ [.]	14/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	resident insists on s - assess and addre - off to "trade" with the necessary." "For long term man - If the resident is a contract for not taking allowing a cleaning the room appropriation - If the resident is contract for not taking allowing a cleaning the room appropriation - If the resident is contract for not taking allowing a cleaning the room appropriation - If the resident is contract for not taking allowing a cleaning the room appropriation - If the resident is contract for not taking back to the room and place. - Limit the availabilities tends to take (extransistic contracts) - Set a routine for change of the state of the state present to help devent rather than have the some of his/her objing family/friend/clergy assist. - Reinforce positive - Anticipate needs set During the tour, the interviewed and corror of cluttered rooms, multiple electric corrors, multiple electric corrors, multiple electric corrors, the handrails the facility had a portion of maintenance inditional set of the set	storing food in room, ss reasons for hoarding, the resident for another item if agement: able to understand, create a ng items back to room or for schedule. Identify areas of te for storage. apable of understanding, nent that if items are brought nother must be returned in its ty of extra items resident silverware or condiment necking for hoarded items. If at ould be done with the resident elop a trusting relationship e resident "discover" that ects are missing. Arrange for or other trusted person to	F3	323			

		& MEDICAID SERVICES				<u>. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - S	I LOUIS PARK PLAZA	-	201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426		
(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) COMPLETION DATE
F 353	Continued From pa	age 44	F 353			
	483.30(a) SUFFIC PER CARE PLANS	ENT 24-HR NURSING STAFF	F 353			2/23/16
	provide nursing an maintain the higher and psychosocial v	ave sufficient nursing staff to d related services to attain or st practicable physical, mental, vell-being of each resident, as dent assessments and care.				
	The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:					
		ed under paragraph (c) of this urses and other nursing				
	section, the facility	ed under paragraph (c) of this must designate a licensed a charge nurse on each tour of				
	by: Based on observa review, the facility f staffing to ensure r assistance with car reviewed for dignifi facility failed to pro activities of daily liv (R153) who was in residents (R153, R	NT is not met as evidenced tion, interview, and document failed to provide adequate esidents received the required res for 1 of 1 resident (R181) ed care and services, the vide timely assistance with ring (ADLs) for 1 of 4 resident continent of stool, for 2 of 3 181) reviewed for potential r 3 of 4 residents (R13, R153,		F 353 a. The assessments and care p care and related needs will be re and revised for R 181 for dignifie and services, R 153, R 13, and F timely assistance with ADLs for incontinence, and R 153 and R skin integrity and alteration. b. Facility will provide sufficient to provide nursing and related se according to the residents assess	viewed d care 181 for 181 for staffing rvices	

A. BOILDING O1/14/2016 245148 B. WING 01/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA 3201 VIRGINIA AVENUE SOUTH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GTV, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, GTV, STATE, ZIP CODE MANDE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES PREXE EACH DEFICIENCY MUST BE PRECEDED BY FULL PREXE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET SAINT LOUIS PARK, MN 55426 F353 Continued From page 45 addition, for 7 of 7 residents (R166, R183, R125, R187, R192, R9, R9), and 13 of 13 staff members (LPN-C, RN-F, LPN-D, LPN-E, NA-F, NA-D, NA-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 153 of 175 residents who currently resided in the facility. F 353 Findings include: Assessed resident needs not met: > Refer to F241: The facility failed to provide dignified dinning for 1 of 1 resident (R181) observed being assisted with eating by staff who stood while feeding R181. F 300 NS or designee to interview 5 nursing staffing. Audit results will be reviewed at monthly OAPI meeting and the frequency of audits will be changed depending on the results of the audits. PREVENTION PREVENTION PROVIDER'S PLAN OF CORRECTION (EACH COMPLATE) Stafficed to F312: The facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 4 residents (R153), R181) for reviewed repositioning. F 353 R181) reviewed for potential skin breakdown.				A. BUILDIN	lG		
3201 VIRGINIA AVENUE SOUTH SANT LOUIS PARK, MN 55426 OWN ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Difference PREFX TAG Deficiency (EACH OERFECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY F 353 Continued From page 45 addition, for 7 of 7 residents (R166, R183, R125, R187, R192, R9, R3), and 13 of 13 staff members (LPN-C, RN-F, LPN-D, LPN-E, LNA-F, NA-D, NA-B) interviewed expressed concerns and complaints related to insufficient staffing. This tack of sufficient staff had potential to affect all 153 of 175 residents who currently resided in the facility. F 353 Findings include: Assessed resident needs not met: > Refer to F241: The facility failed to provide dignified dinning for 1 of 1 resident (R181) observed being assisted with eading by staff who stood while feeding R181. F 353 F 300 the residents and care observations of 5 residents weekly. DNS or designee to interview 5 nursing staff weekly regarding areas of opportunities identified. F 0. DNS or designee to interview 5 nursing staffing. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits. PRefer to F312: The facility failed to provide timely assistance with activities of aliy living (ADLs) for 1 of 4 resident (R153), R181) reviewed for bovel and bladked in roontimence and for 2 of 3 residents (R153, R181) reviewed for bovel and blacked on adjuly living (ADLs) for 1 of 4 resident (R153), R185, R181) reviewed for potential skin breakdown. Staff R2 Staff R2 Staff R2 Staff R2 Staff R2			245148	B. WING _			14/2016
GOLDEN LIVINGCENTER - ST LOUIS PARK PLZZA SAINT LOUIS PARK, MN 55426 (XM) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENTIFY NOT OF CRETCION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENTIFY NOT OF CORRECTION (EACH DEFICIENCY) (XM) ID PROVIDENT SPLAN OF CORRECTION (EACH DEFICIENCY) F 353 Continued From page 45 addition, for 7 of 7 residents (R166, R183, R125, R187, R192, R9, R3), and 13 of 13 staff members (LPN-C, RN-F, LPN-D, LPN-E, NA-F, NA-D, NA-B), interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 153 of 175 residents who currently resided in the facility. F 353 Findings include: Assessed resident needs not met: > Refer to F241: The facility failed to provide dignified dinning or 1 of 1 resident (R181) observed being assisted with eating by staff who stood while feeding R181. F 353 and plans of care. C. Education provided to all staff relating to provision of stresidents weekly. DNS or designee to interview 5 nursing staffing. Audit results will be reviewed at monthy QAPI meeting and the frequency of audits will be changed depending on the results of the audits. > Refer to F314: The facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 4 resident (R153, R181) reviewed for potential skin breakdown. No No	NAME OF F	PROVIDER OR SUPPLIER					
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRÉCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DEFICIENCY F 353 Continued From page 45 addition, for 7 of 7 residents (R166, R183, R125, R187, R192, R9, R3), and 13 of 13 staff members (LPA-C, RN-F, LPN-D, LPN-E, NA-F, NA-D, NA-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 153 of 175 residents who currently resided in the facility. F 353 Findings include: Assessed resident needs not met: > Refer to F241: The facility failed to provide dignified dinning for 1 of 1 resident (R181) observed being assisted with eating by staff who stood while feeding R181. F 363 > Refer to F282: The facility failed to follow the care plan for 3 of 4 residents (R153, R181) for reviewed repositioning. DNS or designee to interview 5 nursing staffing. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits. > Refer to F312: The facility failed to provide timely repositioning for 2 of 3 residents (R153, R181) reviewed tor potential skin breakdown. F 813, R181) reviewed tor potential skin breakdown.	GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA				
 addition, for 7 of 7 residents (R166, R183, R125, R187, R192, R9, R3), and 13 of 13 staff members (LPN-C, RN-F, LPN-D, LPN-E, NA-F, NA-D, NA-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 153 of 175 residents who currently resided in the facility. Findings include: Assessed resident needs not met: > Refer to F241: The facility failed to provide dignified dinning for 1 of 1 resident (R181) observed being assisted with eating by staff who stood while feeding R181. > Refer to F282: The facility failed to follow the care plan for 3 of 4 residents (R13, R153, R181) for reviewed for bowel and bladder incontinence and for 2 of 3 residents (R153, R181) for reviewed repositioning. > Refer to F312: The facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 4 resident (R153), who was incontinent of stool. > Refer to F314: The facility failed to provide timely repositioning for 2 of 3 residents (R153, R181) reviewed for potential skin breakdown. 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETIC
timely assistance with incontinence care for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence.	F 353	addition, for 7 of 7 r R187, R192, R9, R3 members (LPN-C, I NA-D, NA-B) intervi and complaints relat This lack of sufficie all 153 of 175 reside the facility. Findings include: Assessed resident i > Refer to F241: The dignified dinning for observed being assist stood while feeding > Refer to F282: The care plan for 3 of 4 reviewed for bowel for 2 of 3 residents repositioning. > Refer to F312: The timely assistance w (ADLs) for 1 of 4 re incontinent of stool. > Refer to F314: The timely repositioning R181) reviewed for > Refer to F315: The timely assistance w residents (R13, R15)	residents (R166, R183, R125, 3), and 13 of 13 staff RN-F, LPN-D, LPN-E, NA-F, iewed expressed concerns ited to insufficient staffing. In staff had potential to affect ents who currently resided in needs not met: he facility failed to provide '1 of 1 resident (R181) sisted with eating by staff who R181. he facility failed to follow the residents (R13, R153, R181) and bladder incontinence and (R153, R181) for reviewed he facility failed to provide ith activities of daily living sident (R153) who was he facility failed to provide for 2 of 3 residents (R153, potential skin breakdown. he facility failed to provide ith incontinence care for 3 of 4	F 35	 and plans of care. c. Education provided to all state to provision of sufficient nursing meet the residents needs accord assessments and plan of care. will be completed with sample of and staff to help determine opp for improvement relating to nursitaffing. Action plans will be imbased on opportunities identified. DNS or designee to complet audit and care observations of weekly. DNS or designee to in nursing staff weekly regarding areas of opportunity for sufficient nursing DNS or designee to interview 5 weekly regarding areas of opport for sufficient nursing staffing. Areas of opporting and the frequency of a be changed depending on the interview of the sufficient of the suffic	g staffing to rding to Interviews of residents ortunities sing uplemented ed. ete call light 5 residents terview 5 areas of g staffing. residents ortunities Audit thly QAPI udits will	

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	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/02/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245148	B. WING _				01 / ⁻	14/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 353	10/7/15, indicated F required extensive staff with personal I with toileting, dress In addition, the MD3 walker and wheelch On 1/11/16, at 4:29 asked if he felt ther to make sure you g need without having stated, "Sometimes I have my button fo just need ice." R183's quarterly MI cognition was mode independent with al (ADLs). On 1/11/16, at 4:52 asked if he felt ther to make sure you g need without having stated, "They are p for a long time and long time." R125's quarterly MI cognition was intac physical assistance mobility, dressing, t In addition, the MD3 wheelchair for mob	nimum Data Set (MDS) dated R166 had intact cognition physical assistance of one nygiene and was independent ing, transfers and bed mobility. S indicated R166 used both a nair for mobility. p.m. during interview when e was enough staff available et the care and assistance you g to wait a long time resident a the staff ignore you and when r a long time and sometimes I DS dated 10/8/15, indicated erately impaired and was I activities of daily living p.m. during interview when e was enough staff available et the care and assistance you g to wait a long time resident evaluation of the transformation of the staff available et the care and assistance you g to wait a long time resident eople here who have to wait this people are calling for a DS dated 11/10/15, indicated t and required extensive of one to two staff with bed oileting and personal hygiene. S indicated R125 used a	F 3	53				

Facility ID: 00943

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		AND HUMAN SERVICES			FORM	03/02/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER	·		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	asked if he felt ther to make sure you g need without having stated, "Takes a littl and can be even loo R187's quarterly MI cognition was intact extensive physical a dressing, toileting, t hygiene. In addition used a wheelchair f behaviors. On 1/11/16, at 2:59 asked if he felt ther to make sure you g need without having stated, "I have had from waiting for sta in a pad and I don ' was able to transfer had to call them wit This morning we had this floor." R192's quarterly MI cognition was intact extensive physical a dressing, toileting, t hygiene. In addition used a wheelchair f functional limitation side of the lower ex	Per was enough staff available get the care and assistance you g to wait a long time resident le before they come an hour nger." DS dated 12/10/15, indicated t and R187 required limited to assistance of one staff with transfers and personal h, the MDS indicated R187 for mobility and had no p.m. during interview when re was enough staff available get the care and assistance you g to wait a long time resident plenty of accidents right now ff to assist me. They have me 't like them. Before my fall, I r myself not anymore. I have th my phone I don 't hesitate. ad one aide for 30 residents DS dated 11/7/15, indicated t and required limited to assistance of one staff with transfers and personal h, the MDS indicated R192 for mobility and had a i in range of motion on one	F 353			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245148	B. WING			01 / [.]	14/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		-	201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	need without having stated staff would g answering the call li going to get assista R49's quarterly MD cognition was mode total to extensive ph with dressing, toileti hygiene. In addition a wheelchair for mc On 1/12/16, at 9:10 asked if he felt there to make sure you g need without having stated, "Weekends, hardly any staff aron not planning well." R3's quarterly minin R3 was cognitively schizophrenia. During interview on said they are under problem for me but especially in the eve concerns are share They told us that wa new sub acute unit.	et the care and assistance you g to wait a long time resident o out of the room after ight and would indicate were nce. S dated 11/4/15, indicated erately impaired and required hysical assistance of two staff ing, transfers and personal , the MDS indicated R49 used obility and had no behaviors. a.m. during interview when e was enough staff available et the care and assistance you g to wait a long time resident , especially Sunday there is und. I suppose it's my fault for num data set (MDS) indicated intact with a diagnosis of 1/13/16, at 12:30 p.m. R3 staffed here. "It is not a it is for other residents ening or the nights. Staffing d at resident council regularly. as why they could not open the "	F 3	53			
		a.m. licensed practical nurse shift was usually sometimes					

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		AND HUMAN SERVICES	1			APPROVE 0938-039
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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) COMPLETIO DATE
F 353	short staff and had and repositioning re assistance. LPN-C possible to finish th a pink slip to finish th a pink slip to finish th most of the times h needs and had to h needs were attended On 1/13/16, at 6:21 stated the night shift other shifts when a was supposed to w would not be staffed the work. When asl manageable RN-F best you can and w help and if they dor stated on shifts like and resident needs During interview on said, "I some times p.m.'s [evening shift night and did a dou your work done? RI Nights is easier. Or need two nurses ar have a TMA you ha you have to leave th Paperwork. etc not treatment." On 1/13/16, at 7:58 there were two nurs and the units share the units to pass mutimes if the unit was	to help the aides with turning esidents who required two indicated at times it was not e workload and had to ask for the work. LPN-C further stated ad to prioritize the resident ave residents wait before their ed to which would be a while. a.m. registered nurse (RN)-F ft was not short staff but on trained medication aide (TMA) ork with a nurse most times d and the nurse had to do all ked if the workload was stated "You can only do the rould ask the supervisor to n't you do the best." RN-F	F 3	53		

Facility ID: 00943

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245148	B. WING _		01	/14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 353	Continued From pa	-	F 35	53		
	thought was good a lot more including i units were staffed v (NAs) and did not t	ed by a nurse which LPN-D as the nurse was able to do a nsulin's. LPN-D stated the with two nursing assistants hink the two NA's were enough				
	and gave an example if both the NA's went to a room to assist a resident who required two staff to transfer or complete care it was hard and was not just enough and other residents had to wait which at times was a long time.					
	continuous observa station, several res to the LPN-E asked medications. LPN-E and told them she a.m. when asked if the medication pas "I have not even sta on multiple times b rooms for assist wir unit to go get pain r located in 2 East w passing medication windows for some	E was heard re-direct residents would bring it to them. At 9:18 she was running behind with s LPN-E stated as she smiled arted." LPN-E was observed eing interrupted into resident th cares and was leaving the medications out of the machine hich took time away from as timely and the screen of the residents had even dicated the medication pass				
	sufficient nursing N get the workload do resident needs wer repositioning, turnin stated "We try but s it because it is so h	a.m. when asked about IA-F stated it was difficult to one. When asked if the re met timely such as ng and toileting needs NA-F sometimes we just can't get to reavy and the resident 's ot and not being able to get to				

Facility ID: 00943

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		& MEDICAID SERVICES			OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING _		01	/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 353	working but was no pass going. DNS st process of hiring a DNS verified lookin window LPN-E was administration reco -At 9:48 a.m. R46 a overheard indicate for her medications resident request. -At 9:50 a.m. after o DNS attention, thre assist LPN-E with t all the computer sc be red with all the r an untimely fashion - At 2:47 p.m. NA-E NA-B stated, "right When asked about bathroom and to be can not always do t and repositioning a need two people ar minutes and you ne can you fix it?" - At 2:55 p.m. NA-E time to do the repo- two hours. We are best." On 1/14/16, at 10:1 under staffed and s unit need two staff use the transfer ma combative and if tw half hour they is no	d of observations of LPN-E ot able to get the medication tated the facility was in the TMA for 2 South and 2 North. Ig into the computer screen s on the screen for medication rd red. approached LPN-E and was to LPN-E she was still waiting s. LPN-E acknowledged concern was brought to the re nurses were observed to he unit medication pass and reen windows were noted to medications that were being in		53		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLI	TIPLE CONSTRUCTION	(Y3) DA). 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:				MPLETED
		245148	B. WING			/14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ	
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA				
(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 CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 353	Continued From pa	ge 52	F 3	53		
	and for 27 residents	s for two aides with heavy				
	cares it's impossible	e. I have not even taken a 15				
	minute break and in 20 minutes will be lunch here					
	coming and am sha					
	follows:	pattern was based on units as				
	Unit 1 North- Censu	16.23				
		se manager (NM), two RN, and				
	three NA's					
		one nursing supervisor (SUP)				
		nurses, and three NA's.				
	-Night shift- one SUP in building, one RN, and					
	two NA's (depending on acuity or admits can add					
	staff).	s 29 & 2 South-Census 30				
		e assigned to 2 North and one				
		2 South, one TMA who went				
		nd 2 South to assist with				
		tration, three + two and a half				
		with some varying hours to				
		g up and dressed, or ready for				
	bed.					
		e nurse assigned to 2 North gned to 2 South, one TMA				
		2 North and 2 South to assist				
		ministration, two and a half $+$				
		l of 5) CNA's with varying				
	hours.					
		rse and one NA for each side.				
	Unit 2 East- Census					
	-Evening shift two r	three nurses, and six NA's nurses and one TMA or three				
	nurses, and five NA -Night shift two nurs					
	Unit ACU Census 2	7 and AACU Census 25 (staff				
	as one unit).					
		and one nurse on each side 5				
	NA's with varying h					
	-Evening shift one r	nurse on each side and five	1			1

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		AND HUMAN SERVICES			F		APPROVED
		& MEDICAID SERVICES	. 				0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING			01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH		
				- 5	SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 53	F 3	53			
	NA						
	0	se between the sides and two					
	NA's. Weekend superviso	or day shift, rotates between					
	the nurse managers	s, the evening and night					
	supervisors are hire vacant).	ed positions (one currently					
		heets were reviewed and were					
		from the changes and the staff					
		show a progressive decline in written in), vs hand written in					
	staff. Example, on \	Wednesday 1/6/16, for the					
		vere typewritten onto the ere hand written 46% were					
		edule was planned; NA's on					
	1/6/16, 24 were type	ewritten in and 26 were					
		were added after the ned. One nursing supervisor					
		lays to evenings and two					
	LPN's did doubles f	from days to evenings.					
	The facility DNS an	d staffer felt the facility was					
	able to cover all shi	fts budgeted hours by					
		osition of the staff when nurse increase TMA or NA					
		and unable to fill than					
	increase nurse hou	rs).					
	The DNS had acted	d as the evening supervisors					
	twice in the past yea	ar, with a census over 170.					
		aff work really well and shifts s not easy and we are not at					
	optimal staffing eve						
		that 60% of RN/LPN FTE (full					
		0 hour per pay period) was to the hiring occurring at a					
		e NA open FTE was 58.1%,					

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		AND HUMAN SERVICES				FORM	: 03/02/2010 APPROVEI . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245148	B. WING			01/	14/2016
	ROVIDER OR SUPPLIER	LOUIS PARK PLAZA		320	REET ADDRESS, CITY, STATE, ZIP CODE D1 VIRGINIA AVENUE SOUTH	1	
				SA	INT LOUIS PARK, MN 55426		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 54	F3	353			
	street. The facility w the wage scale, and community.	nd citing more pay down the vas in the process of reviewing d benchmarking with the					
F 371 SS=E	483.35(i) FOOD PF STORE/PREPARE	ROCURE, /SERVE - SANITARY	F3	371			2/23/16
	considered satisfac authorities; and	om sources approved or story by Federal, State or local distribute and serve food ditions					
	by: Based on observat review, the facility f procedures were fo possibility of food b kitchen and in 6 of potential to 171 of 1	NT is not met as evidenced tion, interview, and document ailed to ensure food sanitation llowed to minimize the orne illness in the main 7 kitchenettes. This had the 175 who were served food			F 371 a. Stand up mixer, dishwasher, cans, frying pans, streamer, and t kitchenettes appliances will be cle address the cited concerns. b. Cleaning and observation of	unit eaned to	
	and/or fluids out of 6 of 7 kitchenettes and the main kitchen. Findings include:				sanitation of kitchen equipment a kitchenette appliances completed c. Sanitation policy reviewed an remains current relating to kitcher sanitation. All staff will be educat	daily. d า	
	11:48 a.m. to 12:52 dietary (DD) the foll	and facility tour on 1/11/16, at p.m. with the director of lowing was observed:			daily cleaning of kitchen equipme unit kitchenette appliance daily. V educated on deep cleaning on a v monthly basis as scheduled.	nt and Vill veekly/	
	oven was observed	nixer stationed next to the I to have a clean mixing bowl ardened food splatter and			 DDS or designee will complet audits of staff cleaning assignmen schedules, and audit all kitchen 		

Facility ID: 00943

If continuation sheet Page 55 of 84

	-	& MEDICAID SERVICES			C		APPROVEI 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED	
		245148	B. WING			01/	14/2016	
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA		3	TREET ADDRESS, CITY, STATE, ZIP CODE 201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426	<u> </u>		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	bottom arm, backsi underside of the mi contact with the del needed to be clean yesterday" after asl asked one staff to d -The dishwasher w white flaky porous I dishwasher and on Inside the dishwash observed a chute/v build up which flake stated the dishwash and then after each -Three 32 gallon Br between the steam the gas stove and d food prep station an across from the gas approximately 22 ir to be dirty, covered debris and spatters cans. -Two large frying pa stove and the inside a black substance of pans. DD verified s cleaned. On a folloo frying pans were ag with heavy black bu surface and the entities.	The food debris around the ide and on and around the ixer. Food would come in bris. The DD verified the mixer led, stating "It was used king one of the staff he then clean it. as observed to have heavy lime build up all around the the inside of the clean side. her on the clean side was ent that had heavy porous lime ed off with touch. DD verified her was de-limed once a week in use the staff cleaned it. rute trash cans stationed er and food warmer; between byten and another between the nd the one compartment sink is stove and oven which was nches were all three observed with heavy amounts of food in the entire outside of the tated they were going to be w up tour on 1/12/15, the two gain observed on the stove still uildup on the inside cooking tire side.		371	equipment and 1 unit kitchenette v ED or designee to complete week of 5 bathrooms for toilet in good re Audit results will be reviewed at m QAPI meeting and the frequency of will be changed depending on the of the audits.	ly audit epair. onthly of audits		
	was observed with	he oven below the microwave heavy black charcoal like stuff d on the racks. When asked						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/02/2016 FORM APPROVED OMB NO: 0938-0391

		AND HUMAN SERVICES			FORM	03/02/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	Continued From pa who was responsib stated as far as he use the oven and th used it. When aske stated he was not s department it would addition, DD verified dried on food debris AACU kitchenette, for observed to be slow noted to have stagr which was not drain ware it was dripping cleaned the ice mad was supposed to le in the facility buildin nursing was also at were aware the ice 1 North kitchenette, observed with dried DD verified stated t between meals to re would then clean. D off as cleaned but w 2 North kitchenette, and freezer were of spills in the inside a and food debris. DD sheet had been sign 2 South kitchenette observed with brow inside. In addition the	age 56 le for cleaning the oven, DD knew his dietary staff did not hought activities department ed who cleaned the oven DD sure and "if it was my d be the first time to know." In d the microwave had brown s on the inside. the resident ice machine was wly dripping near the spout and hant water in the catch basin hing the DD stated he was not g and there was someone who chine three times weekly and thim know to put a work order ag engines. DD further stated ole to put a work order if they machine was dripping. , the resident microwave was d brown yellow food splatters there was a staff who came estock the refrigerators and DD verified it had been signed was not. , both the resident refrigerator bserved to have dried on juice and the freezer had cardboard D verified stated the cleaning ned off also but was not clean. e, the resident microwave was rn dried on food spatters in the he resident toaster was ry buildup deposits of greasy	F 371	DEFICIENCY)		
	inside. In addition the observed with heav old bread crumbs in	he resident toaster was				

If continuation sheet Page 57 of 84

		& MEDICAID SERVICES				0.0938-039
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· /	TE SURVEY MPLETED
		245148	B. WING		01	/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 371	heavy bread crumb 2 East fridge kitche was observed with door seal in the ins underneath the crist dried buildup was r toaster was noted v crumbs in the insid would be cleaned. On 1/11/16, at 5:30 kitchen tour, the ste observed to have b build up coating rer Upon the cook ope up the aluminum for steel containers we dried on stains. Wh DD and cook both condensation in the On 1/13/16, at 9:58 the frying pans wer down on the stove. them over and both heavy substance of entire sides. DD sta cleaned. Immediate aides clean them. A observed cleaning cleaner then was s able to get the blac heard ask the dieta	aned daily. Acknowledged the os buildup. enette, the resident refrigerator dried juice spills around the ide and at the bottom spy drawers a heavy brown noted. In addition, the resident with heavy deposits of bread e grates DD verified stated p.m. during a follow up eamer glass door was been cleaned however a white mained in the inside and door. ning the steamer for meal set oil used to cover the stainless ere all observed to have white hen asked what the stains were stated was from the steam	F 37			

Facility ID: 00943

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		. 0938-039 E SURVEY
	PF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		245148	B. WING			/14/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 371	buildup would also opened the steame buildup and verified was a thin film of du	ge 58 ative who had indicated the come back. DD and surveyor r and DD verified the lime I on the bottom of the steamer ust that was collecting.	F 371			
F 372 SS=F	indicated "It is the p department to pract techniques for clear outbreak of foodbor Service employees Food code 4-601.1" surfaces, nonfood-outensils.* (1) Equipment, food utensils must be cle (2) The food-contac equipment and pan encrusted grease d accumulations. (3) Non-food-contac be kept free of an a residue, and other of 483.35(i)(3) DISPO PROPERLY	bolicy of the Dining Services tice proper sanitation in equipment to prevent the rne illness, and to train Dining to use these techniques Equipment, food-contact contact surfaces, and d-contact surfaces, and ean to sight and touch. et surfaces of cooking s must be kept free of eposits and other soil et surfaces of equipment must accumulation of dust, dirt, food debris" SE GARBAGE & REFUSE	F 372			2/23/16
	properly. This REQUIREMEN by: Based on observat review, the facility fa containment of gark to prevent attracting	NT is not met as evidenced ion, interview, and document ailed to ensure proper bage in the outside dumpster g pests and rodents. This had ct all 175 residents residing at		F 372 a. The debris on the ground dumpster has been removed b. Observation of the dump completed daily for needed p	ster area	

Facility ID: 00943

If continuation sheet Page 59 of 84

	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
ND FLAN C	or connection	IDENTIFICATION NOMBER.	A. BUILDIN	G	CON	FLETED
		245148	B. WING _			14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3201 VIRGINIA AVENUE SOUTH	DE	
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 372	Continued From pa	ige 59	F 37	2		
	the facility.	-		c. Waste disposal policy rev		
	Findings include:			remains current. Staff educa proper trash disposal appropries receptacles and not on the gr	riately in the	
	facility main garbag observed littered w soiled gloves, used	0 a.m. during a tour to the ge dumpster the area was ith slices of bread, multiple incontinent products all impster and underneath the		d. DDS or designee will con audit of dumpster area for de ground. Audit results will be monthly QAPI meeting and th of audits will be changed dep the results of the audits.	nplete weekly bris on the reviewed at ne frequency	
	the director of dieta same heavily littere day. During the tou another staff were i the dumpster the di area was heavily lit and a mattress was When asked who w the area the district effort. When asked ensuring the area w	ubsequent visit to the area with ary the area remained the ed as noted on the previous r the district manager and in the area walked all around istrict manager verified the tered around and underneath is lying next to the dumpster. was responsible for cleaning manager stated was a group who was responsible for vas clean was not really able ed was going to have the area				
	stated his staff had garbage was dispo- noticed the area wa	0 a.m. the director of dietary been trained to ensure all the sed of properly and if the staff as littered they were supposed eaning the area and make sure age lying around.				
	indicated "The Dininhold, transfer and c that does not create for insects and rode	licy reviewed 2/12/15, ng Service department will lispose of waste in a manner e a nuisance or breeding place ents, or otherwise permit the ease." The policy directed staff				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
		045140				
		245148	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	01	/14/2016
	PROVIDER OR SUPPLIER	T LOUIS PARK PLAZA	:	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 372	Continued From pa	-	F 372			
F 431	and free of debris.'		F 431			2/23/16
SS=D	The facility must er a licensed pharma of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accordar professional princip appropriate access instructions, and th applicable.	RUGS & BIOLOGICALS mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug er and that an account of all maintained and periodically als used in the facility must be nce with currently accepted oles, and include the sory and cautionary the expiration date when				
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.				
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can I.				

Facility ID: 00943

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	(10) 111		O	FORM MB NO.	03/02/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245148	B. WING			01 / ⁻	14/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426		
(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 431	Continued From pa	lge 61	F 4	31			
	by: Based on observat review, the facility f medications were of units reviewed for r the facility failed to were disposed of in resident (R26) who Findings include: R26 was admitted t admission diagnose and major depressi The Physician Orde (antianxiety medicatorial ordered 1/6/15, R20 2015, 16 doses in F March 2015, zero of doses in July 2015, doses in Septembe 2015, zero doses ir in December 2015, However, the Loraz remained in the sec until discovered 1/1 The annual Care At 7/9/15, indicated ch depression. The ca indicated impaired impaired communic (MDS) dated 9/18/1 cognitively impaired	ers indicate Lorazepam attion) Intensol solution was 6 received 1 dose in January February 2015, zero doses in loses in April 2015, zero doses doses in June 2015, zero 2 doses in August 2015, zero er 2015, zero doses in October in November 2015, zero doses and was discontinued 1/5/16. zepam Intensol solution cured medication refrigerator			 F431 a. R26 medication removed and destroyed per policy b. All narcotic medications will be reviewed for proper labeling and reafrom medication storage areas. c. Storage of medication policy re and remains current. All licensed s be educated to the Storage of Medipolicy. d. DNS or designee will audit 1 ur medication storage area for proper storage and expired medications. A results will be reviewed at monthly meeting and the frequency of audits be changed depending on the result the audits. 	viewed taff will ication hit wudit QAPI s will	

If continuation sheet Page 62 of 84

IMENT OF HEALTH	AND HUMAN SERVICES			FI		APPROVED
		1				0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
	245148	B. WING			01 / [.]	14/2016
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
I LIVINGCENTER - ST	LOUIS PARK PLAZA					
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	ge 62	F 4	31			
medication storage station (the unit whe registered nurse (R that a key was brok box, in the refrigera and attempted to ex that was not succes remove the padlock The lock box contai solution 2 milligram with approximately the bottom of the m was emptied). The written on it (to indic medication book the There were three m 127, and 35. Page a have been in the via	room in the 1 North nursing ere R26 resided), with N)-H and RN-G it was noted ten off in the narcotic storage tor. Maintenance-A was called xtract the broken key, when ssful a bolt cutter was used to k with the key broken off in it. ined Lorazepam Intensol s/milliliter (ml) labeled for R26, 12 ml remaining in the vial (at teniscus, once the dropper top medication box had numbers cate what page in the narcotic e record could be found. umbers written on the box, 84, 84 indicated 13 mls should al.					
morning narcotic co mediations stored a and counted, but ne actually gone to the locked box to count lock box and not the counted. RN-G and to be determined w the padlock, even th signed the narcotic count had been cor Intensol had last be (more than 4 month On 1/13/15, at 1:19	bunt which verified that all and locked had been reviewed either of the nurses had e refrigerator and opened the t the drug. RN-G verified the e medication itself had been I RN-H verified it was unable then the key was broken off in hough RN-G and RN-H had books as if a full and accurate mpleted. The Lorazepam een administered on 8/28/15 ns prior).					
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER I LIVINGCENTER - ST SUMMARY STA (EACH DEFICIENCY REGULATORY OR L3 Continued From pa On 1/13/15, at 1:00 medication storage station (the unit whe registered nurse (R that a key was brok box, in the refrigera and attempted to ex that was not success remove the padlock The lock box contai solution 2 milligram with approximately the bottom of the m was emptied). The written on it (to indic medication book the There were three m 127, and 35. Page a have been in the via Both RN-H and RN morning narcotic co mediations stored a and counted, but ne actually gone to the locked box to count lock box and not the counted. RN-G and to be determined w the padlock, even the signed the narcotic count had been cor Intensol had last be (more than 4 monthe On 1/13/15, at 1:19 service (DNS) arrive	DF CORRECTION Í ÍDENTIFICATION NUMBER: 245148	RS FOR MEDICARE & MEDICAID SERVICES FOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245148 B. WING PROVIDER OR SUPPLIER 245148 B. WING ALUVINGCENTER - ST LOUIS PARK PLAZA IDENTIFICATION NUMBER: ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 62 F4 On 1/13/15, at 1:00 p.m. during a review of medication storage room in the 1 North nursing station (the unit where R26 resided), with registered nurse (RN)-H and RN-G it was noted that a key was broken off in the narcotic storage box, in the refrigerator. Maintenance-A was called and attempted to extract the broken key, when that was not successful a bolt cutter was used to remove the padlock with the key broken off in it. The lock box contained Lorazepam Intensol solution 2 milligrams/millilier (mI) labeled for R26, with approximately 12 ml remaining in the vial (at the bottom of the meniscus, once the dropper top was emptied). The medication box had numbers written on it (to indicate what page in the narcotic medication stored and locked nad been reviewed and counted, but neither of the nurses had actually gone to the refrigerator and opened the locked box to count the drug. RN-G verified that all mediations stored and locked had been reviewed and counted, but neither of the nurses had actually gone to the refrigerator and opened the locked box to count the drug. RN-G verified the lock box and not the medication itself had been counted. RN-G and RN-H verified it was unable to be determined when the key was broken off in the padlock, even	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA (X2) MULTIPL A. BUILDING. 245148 B. WING	Image: Signed Reciprocess OI SP CPM REDICARE & MEDICAID SERVICES OI SP CPM REDICARE & MEDICAID SERVICES OI SPECIFICATION REPUER A BUILDING ALVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, CITY, STATE, ZIP CODE SUMMATY SIATEMENT OF DEFICIENCIES BUILTIPLE CONSTRUCTION REACH DEFICIENCY WIND TE FRICEMED BY FULL PROVIDER PLAND FORMED TO PERCIENCIES REACH DEFICIENCY WIND TE FRICEMED BY FULL PROVIDER PLAND FORMED TO PERCIENCIES REACH DEFICIENCY WIND TE FRICEMED BY FULL PROVIDER PLAND FORMED TO PERCIENCIES REACH DEFICIENCY WIND TE FRICEMED BY FULL PROVIDER PLAND FORMED TO PERCIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION TAG Continued From page 62 F 431 On 1/13/15, at 1:00 p.m. during a review of medication storage room in the 1 North nursing station (the unit where P26 resided), with registered nurse (RN)-H and RN-G it was noted that a key was broken off in the narcotic storage box, in the refigerator. Maintenance-A was called and attempted to extract the broken key, when that was not successful a bolt cutter was used to remove the pacilock with the key broken off in th. The lock box contained Lorazepam Intensol solution 2 milligrams/millight(m(m)) labeled for R26, with approximately 12 ml remaining in the vial (at the bottom of the metication box had numbers written on the took. R4, 127, and 35. Page 84 indicated 13 mls should have been in the vial. Both RN-H and RN-G ha	IMENT OF HEALTH AND HUMAN SERVICES FORM SF CPM REDICARE & MEDICAID SERVICES OMB NO. OF CORRECTION (X1) PROVDERSUPPLEXCLA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BULDING (X3) DATI COM 245148 B. WING 01/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2301 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 1UVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, CITY, STATE, ZIP CODE 2301 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) IP PROVIDERS PLANK OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROBS REPERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP Continued From page 62 F 431 IP PREFIX TAG PROVERS PLANK OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROBS REPERCED TO THE APPROPRIATE DEFICIENCY) Continued From page 62 F 431 IP IP IP On 1/13/15, at 1:00 p.m. during a review of medication storage prom in the 1 North nursing station (the unit where R25 Freisched), with that was not solic cutter was used to remove the padlock with the key broken off in it. The lock toos contained Uncareapam Intensiol solution 2 milligrams/milliliter (mi) labeled for R26, with approximately 12 mi remaining in the vial (at the bottom of the meniscus, once the dropper top was empticed). The emdication tox had numbers with approximately 12 mi revified that all mediations stored and locked had been reviewed and countle diver MC-6 and RN-H had Signe

If continuation sheet Page 63 of 84

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		IDENTIFICATION NUMBER:	A. BUILDI	NG		WIFLEIEU
		245148	B. WING			/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3201 VIRGINIA AVENUE SOUTH	ODE	
GOLDE	I LIVINGCENTER - ST	LOUIS PARK PLAZA		SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 431	to her previously. D was supposed to be verification of the m had not been comp she did not believe been diverted (and of abuse and that w up). On 1/13/15, at 1:38 another medication showed the 13 mls, been administered, after the medicatior and the new volume The Lorazepam Inte been destroyed at t months ago). The D was supposed to be not had time yet. Th 12/5/15. The DNS w pharmacy service p room inspections at The delivery label w medication had first 2/20/15 at a volume five different rooms documentation of th to be fully provided indicating where the transferred were no narcotic medication of what page and w medication had bee	ge 63 that no-one had reported that NS verified the narcotic count e a visual count and redications on the unit, and it leted accurately. DNS stated any Lorazepam Intensol had that it was considered a drug vas why it had been locked p.m. DNS located page 5 in cart and narcotic book, which an additional three doses had last on 8/28/15 (3 months in should have been destroyed) e total was now 12.25 mls. ensol solution should have he end of May 2015, (7 DNS stated the medication e destroy [request] was dated verified the consultant performed periodic medication in the facility, and the the medication use was unable at that time (the notes e medication had been it present). DNS verified the books lacked documentation that medication cart the en moved to, the narcotic uplicate pages that were not	F 4	31		

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		AND HUMAN SERVICES				FORM	03/02/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245148	B. WING			01/	14/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	broken off in the pa did not include all of the unit. On 1/14/16, at 12:3 pharmacist (CP) sta building in July, so been an audit of the unsure when the pr audited. CP stated day expiration for the stated if it was a mu until the manufactu been compounded sooner. CP stated it to audit all the fridg According to the pa 2012, the Lorazepa 36 to 46 degrees F days after the medi The Storage of Med directed: "Medications and b following manufactu those of the supplie to support safe adm supply is accessible	determined when the key had adlock, as the narcotic counts of the secured medications on 80 p.m. the consultant ated he had taken over the January 2016 would have e medication rooms. He was revious pharmacist last he was not aware of the 90 ne Lorazepam Intensol, and ulti-dose vial it should be good rer 's expiration date. If it had , the expiration would be much the plan of correction would be	F 4	31			
	 Medications are and may include m rooms, medication containers. Non-controlled m 	hister medications." kept in controlled environment, edications carts, medication cabinets, or other suitable nedication that have been rsing care center, as having					

If continuation sheet Page 65 of 84

TATEMEN	F OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		BERTH IOATION TOWBER.		IG	001	
		245148	B. WING _		01/	14/2016
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA		STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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) COMPLETIO DATE
F 431 F 441 SS=E	the potential for abu controlled substance solution]. 11. Mediations requi temperatures betwe are kept in a refrige 14. "Outdated or co deteriorated medica that are cracked, so closures are immed disposed of accordi medication disposa 16. "Medication stor on a regular basis a ("QA") check. Reco corrective action tal identified." 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infect (a) Infection Contro The facility must es Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to	 Jise may also be stored with thes. [Lorazepam Intensol Jiring refrigeration or even 36-46 degrees Fahrenheit rator with a thermometer. Intaminated, discontinued or ations and those in containers biled, or without secure diately removed from stock, ing to procedures for l. rage conditions are monitored as a random quality assurance immendations are made for ken as problems are I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. 	F 43			2/23/16

If continuation sheet Page 66 of 84

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245148	B. WING _		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
				3201 VIRGINIA AVENUE SOUTH		
GOLDER	LIVINGCENTER - 5	T LOUIS PARK PLAZA		SAINT LOUIS PARK, MN 554	26	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E			(EACH CORRECTIVE ACT		COMPLÉTIO DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DATE
F 441	Continued From pa	age 66	F 44	1		
		resident needs isolation to				
		d of infection, the facility must				
	isolate the residen					
		st prohibit employees with a				
		ease or infected skin lesions				
		t with residents or their food, if				
		ransmit the disease.				
		st require staff to wash their lirect resident contact for which				
		dicated by accepted				
	professional practi					
	(c) Linens					
		andle, store, process and				
		as to prevent the spread of				
	infection.					
	This REQUIREME	NT is not met as evidenced				
	by:					
		ation, interview, and document		F441		
		failed to ensure equipment and		a. R93, R153, and R18		
		e kept clean and sanitary for 1 50 residents resided. In		for infectious diseases re		
	addition, the facility			following infection control b. Audit of all surfaces u		
		performed for 2 of 4 residents		medication set-up audited		
		were observed for cares.		Audit of all medication cru for cleanliness. Resident	ushers audited	
	Findings include:			assistance with pericare to e	to be identified at	
	On 1/13/16 at 7:13	a.m. a medication set up and		pericares completed to re		
	administration was	observed for R93, during the		infection. Audit of all resi	dents to identify	
		urse (RN)-K performed hand		those that require wound		
		class of room temperature		c. All licensed staff to be		
		set it on top of the 2 East		Cleaning and Disinfection		
		sk while she prepared 7		care items and equipmer assisting with pericares to		
		hen picked up the glass of nore water to it, then picked up		Perineal Care Procedure		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245148	B. WING _	STREET ADDRESS, CITY, STATE, ZIP (14/2016	
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		Ξ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 441	top of the nursing si and black debris was between the medica without additional has On 1/13/16, at 10:0 (LPN)-F verified the debris in the crushin of the pill crusher. T and black and could fingernail. The pill c three medication cas medication prepara top of the nursing si and black debris was carts were placed in desks and medicati dispensed form the The Cleaning and E Items and Equipme directed: "Resident-care equi items and durable r cleaned and disinfe recommendations f Bloodborne Pathog 1. c. Non-Critical ite where they are used	and entered R93's room. The tation desk had tape debris as stuck to it. RN-K moved ations and the cup of water and hygiene. 0 a.m. licensed practical nurse e Silent Knight Pill crusher had ng area, and along the sides The debris was white, brown d be scraped off with a rushers were on top of the arts, in an area used for tion. LPN-F further verified the tation desk had tape debris as stuck to it. The medication n front of the 2 East nursing ons were sometimes desk area. Disinfection of Resident-Care ent policy dated 8/2014, ipment, including reusable nedical equipment will be cted according to current CDC or disinfection and the OSHA ens Standard. ems can be decontaminated d. low-level disinfectants for clude: opyl alcohol;	F 44	educated to facility Handwa hygiene procedure. d. DNS or designee to co audit of 1 unit weekly to ens surfaces for medication set residents for proper pericar residents receiving wound of handwashing/ hygiene proc results will be reviewed at r meeting and the frequency be changed depending on t the audits.	mplete weekly sure clean -up, 5 es, and 5 care for proper sedures. Audit nonthly QAPI of audits will		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/02/2016 APPROVED 0938-039
-	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
GOLDEN	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTI SAINT LOUIS PARK, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE	(X5) COMPLETION DATE
F 441	11/17/15, indicated required assistance (ADLs), and was all bladder. During observation 1/13/16, from 10:25 registered nurse (R observation. Nursin transferred R153 from mechanical lift. A st R153 lying in bed a NA-B washed hand R153's pants. NA-E incontinence brief. with urine. RN-D ve NA-B wiped abdom NA-B removed glov after using sanitizer on left side. R153's area to the coccyx. immediately above The coccyx had an (cm.) x 1.5 cm non verified coccyx was wiped R153's botton Brown stool observ NA-D washed R153's front, then removed new gloves on with applied new inconti boots on R153's fee removed gloves, str gloves on. NA-D clo brief and incontiner	nimum Data Set (MDS) dated resident was cognitively intact, with activities of daily living ways incontinent of bowel and of incontinence cares on a.m. until 10:35 a.m. and N)-D present for entire g assistant (NA)-B and NA-D om wheel chair to bed with rong odor of urine noted when nd RN-D verified urine odor. s, put on gloves, and removed	F 4	141		

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		AND HUMAN SERVICES				FORM): 03/02/2016 /I APPROVED). 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		TE SURVEY MPLETED
		245148	B. WING			01	/14/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CC		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ige 69	F 4	141			
	resident was mode required assistance	MDS dated 12/22/15, indicated rately impaired cognitively, with ADLs, and was always der and frequently incontinent					
	1/13/16, at 8:46 a.m a.m. NA-D pulled R181 of room. NA-D and Na wheelchair to bed u applied gloves and opened incontinent be red from front to cm above the rectu area blanched. The completely saturated brief was saturated incontinence wipe t to back. NA-E and NA-D wiped R181's stool visible on inco NA-D removed the gloves without was NA-D put R181's pr covered resident up gloves without was R181's eyes and fa During interview on stated, " I know I a	soiled gloves, put on new hing hands or using sanitizer. ants and blue boots on. NA-D b. NA-D applied a new pair of hing hands and washed ice. 1/13/16, at 2:55 p.m. NA-D m to wipe from front to back, them from back to front. I am					
		1/14/16, at 9:22 a.m. the services expected staff to at					

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STATEMENT OF DEFICIENCIES (M) PROVIDERSUPPLIENCIA (M) PROVIDERSUPPLIENCIAN (M) PROVIDERSUPPLIENCIAN (M) PROVIDERSUPPLIENCENT (M) PROVIDER (M) PROVIDER (M) PROVIDERSUPPLIENCENT (M) PROVIDENT (M) PROVIDENT (M) PROVIDENT		-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, CITY, STATE, ZIP CODE MAIN TOUS PARK, INN 55426 SUMMARY STATELENT OF DEPICIENCIES, IEACH DEPICIENCY WIST BE PREVENDED BY FULL RECULATORY ON LSC IDENTIFYING INFORMATION) IPO ON DEPICIENCIES, IEACH DEPICIENCY WIST BE PREVENDED BY FULL RECULATORY ON LSC IDENTIFYING INFORMATION) PROVIDER OF NAME CONCENTRY (EACH OPERCIPTIC ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Over Action (EACH OPERCIPTIC ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 70 least use hand sanitizer when staff remove gloves as long as the gloves are not visible soled. If the gloves are visible soled staff are to wash their hands with soap and water. "We did immediate re-education with the staff involved and then with all staff on hand washing and glove usage. The staff are to wipe a resident from front to back to prevent uniary tract infections. I expect the staff to follow our policy regarding incontinence care and hand washing." F 441 The facility Perineal Care procedure dated 129/15, instructs staff: "11. Female perineal care a. It resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to sub bed pan place resident on he side with legs flexed. I. Use one gloved hand to stabilize and separate the labilize, the policy lacked direction to wash hands or use sanitzer after changing solied gloves. Wound Care	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY
IMAGE OF PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STREE, 2P CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES D REGULATORY ON LISC DESTIFYING INFORMATION) D PREFIX PROVIDER SPLANG CONRECTION Code Resolution of the APROPRIATE DEFICIENCIES F 441 Continued From page 70 least use hand sanitizer when staff remove gloves as long as the gloves are visible solied. If the gloves are visible solied staff are to wash their hands with soap and water. 'We did immediate re-education with the staff involve usage. The staff are to wips a resident from front to back to prevent urinary tract infections. I expect the staff to follow our policy regarding incontinence care and hand washing." F 441 The facility Perineal Care a. If resident is solied with fees, place resident on side and clean perineum and rectal area. b. Change water and discard solied linen appropriately. C. Thange gloves. d. Turn resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to stread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unab			245148	B. WING	i		01/ [.]	14/2016
GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA (YALID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EPCICIENCY MUST BE EPRICEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) PD PMETRY TAG PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRICEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) PMETRY PLAN CORRECTIVE ATION FOR CORRECTION (EACH DEPICIENCY) COMPLETION (EACH DEPICIENCY) F 441 Continued From page 70 least use hand sanitizer when staff remove gloves as long as the gloves are not visible solied. If the gloves are visible solied staff are to wash their hands with soap and water. " We did immediate re-education with the staff involved and then with all staff on hand washing and glove usage. The staff are to wips a resident from front to back to prevent urinary tract infections. I expect the staff to follow our policy regarding incontinence care and hand washing." F 441 The facility Perineal Care procedure dated 12/9/15, instructs staff: "11. Female perineal care a. If resident is solied with fees, place resident on side and clean perineum and rectal area. b. Change gloves. Ask resident to separate her legs and flex knees. Its perineal area can be washed with the resident on the side with legs flexed. I. Use one gloved hand to stabilize and separate the labla, with other hand wash from front to back. F resident is able to use be dpan place resident on back. J. Be neight as be to use be dpan place resident on bedra, and position resident on back. I resident is bale to use be dpan, and position resident on back. Munch Care Wound Care	NAME OF F	PROVIDER OR SUPPLIER						
Principal TAG IEAD-IDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC DENTIFYING INFORMATION) PRETX TAG CEACH CORRECTIVE ACTION SHOLD BE DEFICIENCY COMPLETION DEFICIENCY F 441 Continued From page 70 least use hand sanitizer when staff remove gloves as long as the gloves are not visible soiled. If the gloves are not visible soiled at the gloves are not visible soiled the gloves are not visible soiled at the gloves are not visible soiled. If the gloves are not visible soiled at the organ are not visible soiled at the organ are not visible soiled at the organ are resident from front to back to prevent urinary tract infections. I expect the staff to follow our policy regarding incontinence care and hand washing." F 441 The facility Perineal Care a. If resident is soiled with feces, place resident no side and clean perineum and rectal area. b. Change water and discard soiled linen appropriately. F As resident to separate her legs and flex knees. Its he is unable to spread her legs and flex knees, the perineal area can be washed with the resident to ne side with legs flexed. f. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back. G. If resident is able to use bed pan place resident in one side with legs flexed. f. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back. F 100 Hereineum. h. Dry the area well, remove bedpan, and position resident on back." The policy lacked direction to wash hands or use sanitizer after changing soiled gloves. Hereineum.	GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA					
 least use hand sanitizer when staff remove gloves as long as the gloves are not visible solided. If the gloves are visible solid staff are to wash their hands with soap and water. "We did immediate re-education with the staff involved and then with all staff on hand washing and glove usage. The staff are to wipe a resident from front to back to prevent urinary tract infections. I expect the staff to follow our policy regarding incontinence care and hand washing." The facility Perineal Care procedure dated 12/9/15, instructs staff: "11. Female perineal care a. If resident is solied with feces, place resident on side and clean perineum and rectal area. b. Change water and discard solied linen appropriately. c. Change gloves. d. Turn resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to spread her legs and flex knees. If she is unable to staff are and separate the ladia, with other hand wash from from to to back. g. If resident is able to use bed pan place resident on bey hand to stabilize and separate the ladia, with other hand wash from from to back. g. If resident is able to use bed pan place resident on back." The policy lacked direction to wash hands or use sanitizer after changing solid gloves. 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
7:29 a.m. R153 was sitting in wheelchair. The left	F 441	least use hand sani gloves as long as th soiled. If the gloves wash their hands w immediate re-educa and then with all sta usage. The staff are to back to prevent u the staff to follow ou incontinence care a The facility Perinea 12/9/15, instructs st "11. Female perine a. If resident is so on side and clean p b. Change water a appropriately. c. Change gloves d. Turn resident o e. Ask resident to knees. If she is una knees, the perineal resident on the side f. Use one gloved separate the labia, front to back. g. If resident is ab resident on bedpan cleansing solution of h. Dry the area we position resident on The policy lacked d sanitizer after change Wound Care R153's wound care	itizer when staff remove he gloves are not visible are visible soiled staff are to ith soap and water. "We did ation with the staff involved aff on hand washing and glove e to wipe a resident from front urinary tract infections. I expect ur policy regarding and hand washing." I Care procedure dated taff: eal care iled with feces, place resident berineum and rectal area. and discard soiled linen n her back separate her legs and flex area can be washed with the e with legs flexed. d hand to stabilize and with other hand wash from ble to use bed pan place and pour clean warm water or over the vulva and perineum. ell, remove bedpan, and n back." irection to wash hands or use ging soiled gloves.	F 4	141			

If continuation sheet Page 71 of 84

ATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED
		245148	B. WING		01	/14/2016
JAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 441		ered with gauze. The bottom	F 4	41		
	nurse (LPN)-B was LPN-B used a band	s purple. Licensed practical hed hands and put on gloves. dage scissors from their pocket d gauze dressing. LPN-B did				
	not clean the scisso scant amount of dra on the gauze. LPN-	Bigliable differences in a bigliable difference in a bigliable differe				
	removed the soiled without washing ha surrounding the wo	gloves and put new gloves nds. LPN-B wiped the area und with a barrier wipe, then				
	soiled gloved hands square of alginate,	ng supply caddy with the s and removed an open foam 2 cm by 2 cm dressing LPN-B cut the clean alginate				
	scissors that cut the LPN-B applied San	ressing) with the same soiled e soiled gauze dressing. tyl (a sterile enzymatic using a cotton tipped swab,				
	covered with algina and wrapped with g sock on right foot a	te, then applied foam dressing jauze. LPN-B removed R153's nd wiped right heel with skin ight heel observed to be intact				
	without redness or soiled scissors bac	open areas. LPN-B placed the k into the pocket without ssors, removed the soiled				
	stated, "Generally I glove changes. I ar needed to. I did not cutting off the old d	1/14/16, at 8:01 a.m. LPN-B do not wash hands between n not sure, I did not think I wipe my scissors off after ressing and before cutting the n into the dressing supply				
		es on after I had cleaned the				

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED		
		245148	B. WING _		01	/14/2016		
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
OLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
F 441	Continued From pa	-	F 44	11				
		ve wiped the scissors of with						
		used. DNS said, "I expect staff efore reaching into a bucket of						
		olies. Gloves should be						
		s cleaned with sanitizer or						
	soap and water after	er completing one wound						
	dressing, before do whenever they rem	ing another treatment or ove their gloves."						
		shing/Hand Hygiene August 2014, instructed staff						
	to:	August 2014, Instructed Stan						
	7. Use an alcohol	-based hand rub containing at						
		alcohol, or, alternatively, soap						
	(antimicrobial or no the following situation	n-antimicrobial) and water for						
	a. Before and afte							
		d direct contact with residents;						
		ng or handling medications;						
		ing any non-surgical invasive						
	procedures; e. Before and afte	r handling an invasive device						
		ers, IV access sites);						
	f. Before donning							
		g clean or soiled dressings,						
	gauze pads, etc.;	from a contaminated body site						
		during resident care;						
	i. After contact wi	ith resident's intact skin;						
		ith blood or bodily fluids;						
	k. After handling ι equipment, etc.;	used dressings, contaminated						
		ith objects (e.g., medical						
	equipment) in the ir resident: and	nmediate vicinity of the						
	m. After removing							
	 n. Before and afte settings; 	er entering isolation precaution						
	o. Before and afte		1					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/02/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
		245148	B. WING		01/	14/2016	
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA	STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
F 441 F 465 SS=E	Continued From page 73 p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene." "9. The use of gloves does not replace hand washing /hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a safe, sanitary, free of urine odors, and homelike		F 4		merous spots on 2nd	2/23/16	
	of 175 residents in Findings include: A tour of the facility through 11:00 a.m. (DM), Administrator and Director of Env (housekeeping and were noted to need - The carpet in the I numerous spots thr	on 1/14/16 at 10:00 a.m. with the District Manager r, Director of Maintenance, ironmental Services laundry) the following areas		repaired for numerous marks on wallboard. 116 will be repaired. of room 209 will be re tiles in room 282 will b rooms 209b, 211a, 22 378a with identified un deep cleaned. b. Preventative main place for identification functional, sanitary, an environment. The ED responsible to complete environmental rounds	s gouges and black The gouge in room The gauge on door paired. The missing be replaced. The /223b, 233a, and tine odors will be tenance program in and repair of safe, nd comfortable or designee is tet routine		

Facility ID: 00943

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245148	B. WING			01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 465	Continued From pa	ge 74	F4	65			
	 Room 116A had a behind the bed Room 209 - the er a deep gouge with j Room 282 missing and a bathroom had missing tiles on the dirty The following areas 209 B strong urine 211A strong urine 222B/223B strong bathroom) 233A strong urine 378 A urine odor in At the beginning of a.m. the director of there were no pend after the remodel w completed in 2/16. completed and the 	g tile by the bathroom door, d raised area for the toilet had upper edge, and the floor was had a urine odor: e smell in the bathroom odor in room urine odor in room (shared odor in room			repairs and cleaning to ensure safe functional, sanitary and comfortable environment. c. Education provided to staff on identifying needed repairs and odor and notification of housekeeping ar maintenance for follow up. d. ED or designee to audit weekly resident rooms and 1 unit for safe functional, sanitary and comfortable environment. Audit results will be reviewed at monthly QAPI meeting the frequency of audits will be chan depending on the results of the aud	e r issues nd r 5 e and nged	
F 514 SS=F	end of the tour the lagreed with the env The Director of Env writer a copy of the 01/16. The carpet on 1/6/16 2E, 1/13/ 1/20/16 Extract 2S, Extraction was the carpet. All hallways (one unit each Frida 483.75(I)(1) RES	Director of Maintenance vironmental issues as listed. ironmental Services gave the carpet cleaning schedule for was to have Extract cleaning 16, Extract Center Hall, and 1/27/16 Extract 2N. process to clean spots in the were to be done on Fridays	F 5	14			2/23/16

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		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>				APPROVEI 0938-039
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING _		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From page 75 LE			14		
	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.					
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.					
	by: Based on interview facility failed to main were complete for 1 R108, R151, R187, R103) reviewed for Findings include: R3's Admission Red indicated R3 was at 6/1/15, with diagnos disease, type 2 diat syndrome. The medical record review revealed no medication regimen The Physician's Ord R3 took pain medic	is REQUIREMENT is not met as evidenced ased on interview and document review, the cility failed to maintain accurate medical records are complete for 10 of 10 residents (R3, R211, 08, R151, R187, R42, R126, R154, R164, 03) reviewed for monthly pharmacist reviews. Indings include: It's Admission Record dated printed on 1/14/16, dicated R3 was admitted to the facility on 1/15, with diagnoses including end stage renal acease, type 2 diabetes mellitus and Down's		F 514 a. R3, R211, R108, R151, F R42, R126, R154, R164, and reviewed for complete medica regarding pharmacy reviews. b. Audit of residents at next conference for complete medica regarding pharmacy reviews c. Clinical pharmacist to con- training on ensuring pharmaci are placed in medical records d. DNS or designee to comp audits of 5 residents to ensur- reviews are in medical record results will be reviewed at mo- meeting and the frequency of be changed depending on the the audits.	R103 al records care lical records mplete cy reviews bolete weekly e pharmacy I. Audit onthly QAPI audits will	

Facility ID: 00943

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION		(X3) DA	0. 0938-039 TE SURVEY MPLETED		
		245148	B. WING			01	/14/2016		
	PROVIDER OR SUPPLIER	T LOUIS PARK PLAZA		3201 VIRGINIA AV	, CITY, STATE, ZIP CODE /ENUE SOUTH ARK, MN 55426	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVII (EACH CC	DER'S PLAN OF CORREC ORRECTIVE ACTION SHO FERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
F 514	On 1/14/16, at app director of nursing medical record did regimen review's s expect the monthly readily available for medical record. R211's Admission I 1/14/16, indicated I admitted to the fac including schizoaffe disorder, and anxie R211's Physician's indicated took pain medications, antips medications. The medical record review revealed the regimen review's fr completed on 6/4/1 On 1/14/16, at 8:45 R211's record and consultant review v she have called the help. On 1/14/16, at 12:3 information appear record for R211's n the electronic chart - Effective date: 8/3	roximately 1:10 p.m. the services (DNS) verified R3's not contain any medication ince admission, and would pharmacist reviews to be r review in resident's individual Record dated printed on R211 was most recently ility on 8/7/15, with diagnoses ective disorder, delusional ety disorder. Orders dated 10/25/15, medications, antianxiety sychotic medications and other d (both paper and electronic) e last monthly medication rom the pharmacist was 15. 5 a.m. the DNS reviewed confirmed the last pharmacy was from 6/4/15, and stated e consultant pharmacist for 30 p.m. the following red in the electronic medical nissing pharmacy reviews in	F 5	14					

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		AND HUMAN SERVICES					FORM	: 03/02/2016 APPROVED . 0938-0391		
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G		· · /	E SURVEY IPLETED		
		245148	B. WING	i			01/	14/2016		
NAME OF I	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP	P CODE	•			
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426						
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROP	BE	(X5) COMPLETION DATE		
F 514	R108's admission I dated 11/9/15, inclu hypertension, anxie disease. R108's current adm 10/4/13. The medic taking cyclobenzap fibromyalgia, Fenta chronic pain, fluoxe olanzapine (an anti depression, gabape Xanax for anxiety. The pharmacist more recommendations f 2015 were not avai record (EHR). The that had occurred. R151's quarterly M the following diagnore mellitus, hyperlipide disorder other than admission date of S The pharmacist's la record of a pharma 6/5/15, and there w included in the pap indicated resident v antihypertensive m antianxiety medicat	/31/15, created on 1/14/16; //31/15, created on 1/14/16; //31/15, created on 1/14/16; //31/15, created on 1/14/16; //31/15, created on 1/14/16; ///16, created on 1/14/16; ///16, created on 1/14/16; ///16, created on 1/14/16; ///18, created on 1/14/16; ///18, created on 1/14/16; ///18, created on 1/14/16; ///18, created on 1/14/16; ///19, fibromyalgia, and lung ///19, fibromyalgia, and lung ///19, created not created on 1/14/16; ///10, created not created on 1/14/16; ///12, created on 1	F	514		,				
	about the whereab	services (DNS) was queried outs of the monthly pharmacy fter 6/5/15. The DNS indicated								

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	FOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUIT	IPLE CONSTRUCTIO	ON		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG			MPLETED
		245148	B. WING _				/14/2016
NAME OF	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CC	DDE	
GOLDEN	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA A SAINT LOUIS F	VENUE SOUTH PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	/IDER'S PLAN OF COR CORRECTIVE ACTION S EFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 514		-	F 51	4			
		ontact the facility's consultant e she could not find any after 6/5/15.					
	On 1/14/16, at 12:30 p.m. the following information appeared in the electronic medical record for R151's missing pharmacy reviews in the electronic chart: - 9/29/15 review date, created 1/13/16 at 12:26						
	p.m.	ate, created 1/13/16 at 12:27 ate, created 1/13/16 at 12:28					
	p.m.	ate, created 1/13/16 at 12:29					
	R187's diagnoses in other venous throm (primary) hypertens history of pulmonar (current) use of ant hypercholesterolem edema, hypomagne reflux disease witho generalized anxiety	ia, iron deficiency anemia, esemia, gastro-esophageal					
	review revealed no medication regimen The Physician's Ord R3 took pain medic thinner, antihyperte	(both paper and electronic) record of the monthly review's from the pharmacist. ders dated 11/23/15, indicated ations, antianxiety, blood nsive medications hypnotic (sleep aide)					
	interviewing the cor	p.m. while surveyors were sultant pharmacist the n appeared in the electronic					

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	IPLETED
	245148	B. WING _		01/	14/2016
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE	(X5) COMPLETIC DATE
medical record for F reviews in the electr Effective date: 7/3 Effective date: 8/3 Effective date: 9/3 Effective date: 10/3 Effective date: 11/3 Effective date: 12/3 R42's diagnoses ind disorder, anxiety dis depressive disorder mellitus, and psycho record printed 1/14/ R42's Physician's O R42 took pain medic medications, antipsy diabetes oral medic medications among both paper and ele record of the month review's from the ph On 1/14/16, at 1:30 nterviewing the com ollowing information medical record for F reviews in the electr Effective date: 7/3 Effective date: 8/3 Effective date: 10/3 Effective date: 10/3	A187's missing pharmacy onic chart: 1/15, created on 1/14/16 1/15, created on 1/14/16; 2/15, created on 1/14/16; 30/15, created on 1/14/16; 30/15, created on 1/14/16; 31/15, created on 1/14/16; 31/15, created on 1/14/16; 31/15, created on 1/14/16; corder, dementia, major , hypertension, diabetes basis obtained from admission 16. rders dated 1/14/16, indicated cations, antianxiety ychotic, an antidepressant, ations including and insulin others. The medical record ctronic) review revealed no ly medication regimen harmacist. p.m. while surveyors were sultant pharmacist the n appeared in the electronic A187's missing pharmacy onic chart: 1/15, created on 1/14/16; 2/15, created on 1/14/16; 30/15, created on 1/14/16; 30/15, created on 1/14/16; 30/15, created on 1/14/16;	F 51			
	IVINGCENTER - ST SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS Continued From pag- nedical record for F eviews in the electr Effective date: 7/3 Effective date: 9/30 Effective date: 10/3 Effective date: 11/3 Effective date: 12/3 R42's diagnoses incl lisorder, anxiety dis lepressive disorder nellitus, and psycho ecord printed 1/14/ R42's Physician's O R42 took pain medic nedications, antipsy liabetes oral medic nedications among both paper and eleview's from the ph On 1/14/16, at 1:30 netrviewing the con- ollowing information nedical record for F eviews in the electr Effective date: 7/3 Effective date: 7/3 Effective date: 9/30 Effective date: 11/3 Effective date:		OVIDER OR SUPPLIER IVINGCENTER - ST LOUIS PARK PLAZA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 79 nedical record for R187's missing pharmacy eviews in the electronic chart: Effective date: 7/31/15, created on 1/14/16; Effective date: 10/30/15, created on 1/14/16; Effective date: 10/30/15, created on 1/14/16; Effective date: 11/30/15, created on 1/14/16; Effective date: 12/31/15, created on 1/14/16; R42's diagnoses including schizoaffective lisorder, anxiety disorder, dementia, major lepressive disorder, hypertension, diabetes nellitus, and psychosis obtained from admission ecord printed 1/14/16. R42's Physician's Orders dated 1/14/16, indicated 42 took pain medications including and insulin nedications among others. The medical record both paper and electronic review revealed no ecord of the monthly medication regimen eview's from the pharmacist. On 1/14/16, at 1:30 p.m. while surveyors were netrive wing the consultant pharmacist the ollowing	OWDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE IVINGCENTER - ST LOUIS PARK PLAZA STREET ADDRESS, CITV, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN OF CORRECT (EACH ORRECTIVE, STATE, ZIP CORE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Ontinued From page 79 nedical record for R187's missing pharmacy eviews in the electronic chart: F 514 Effective date: 7/31/15, created on 1/14/16; Effective date: 10/30/15, created on 1/14/16; Effective date: 73/1/5, created on 1/14/16; Effective date: 11/30/15, created on 1/14	DUIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE IVINGCENTER - ST LOUIS PARK PLAZA SITREET ADDRESS, CITV, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 79 nedical record for R187's missing pharmacy eviews in the electronic chart: F 514 Continued From page 79 nedical record for R187's missing pharmacy eviews in the electronic chart: F 514 Effective date: 7/31/15, created on 1/14/16; Effective date: 10/30/15, created on 1/14/16; Effective date: 7/31/15, created on 1/14/16; Effective date: 10/30/15, c

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/02/2010 APPROVEI . 0938-039
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245148	B. WING _		01,	/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
GOLDE	N LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	diabetes mellitus, h chronic kidney dise obtained from admi R126's Physician's indicated R126 tool medications and inso others. The medical record review revealed the regimen review's fro completed on 6/3/1 On 1/14/16, at 1:38 pharmacist stated a documentation from no documentation v electronic resident of reviews had been d pharmacist stated h documents and did they were all showin R154's diagnoses in disorder, post-traum vitamin D deficiency pain, acute embolis veins of lower extre insomnia, hypertens that causes muscle obstructive pulmona Admission Record of R154 was admitted consultant pharmac	yperlipidemia, heart failure, ase stage four and chest pain ssion record printed 1/14/16. Orders dated 1/11/16, multiple antihypertensive sulin medications among (both paper and electronic) last monthly medication om the pharmacist was 5. p.m. the consultant and showed surveyor his n all the past reviews however vas in either the paper or medical record to justify the lone monthly. The consultant he had not created the not have explanation how ng up all of a sudden. Included major depressive natic stress disorder diabetes, y, anxiety disorder, chronic m on thrombosis of deep mity (blood clot in leg), sion, fibromyalgia (a disorder pain and fatigue), chronic ary disease obtained from	F 5			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
		& MEDICAID SERVICES				<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245148	B. WING			01/ [.]	14/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From pa	ige 81	F 5	14			
	R154's Order Summary dated 1/14/16, indicated R154 took pain medications, antianxiety medications, blood thinner medications, and other medications.						
	health record show R154's missing pha electronic chart: - Effective date: 8/3 - Effective date: 9/3 - Effective date: 10/ - Effective date: 11/	9 p.m. review of electronic ed Pharmacy Review for armacy reviews in the 81/15, created on 1/14/15; 80/15, created on 1/14/15; /30/15, created on 1/14/15; /30/15, created on 1/14/15; /31/15, created on 1/14/16;					
	major depressive d	ncluded subdural hemorrhage, isorder, hypertension, chronic ary disease obtained from dated 1/14/16.					
		mary dated 1/14/16, indicated dications, and other					
	consultant pharmac Reviews recorded b	8/9/14. There were no cist's Medication Regimen by the pharmacist for July ember 2015, in R164's chart.					
	disorder, dementia,	ncluded major depressive , hypertension, and atrial from Admission Record dated					
	consultant pharmac Review recorded by	I 4/21/15. There were no cist's Medication Regimen y the pharmacist for July 2015, 2015, in R103's chart.					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVE
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED
		245148	B. WING		01/14/2016
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
BOLDEN	I LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 554	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE
F 514	Continued From pa	ge 82	F 5	14	
	R103 took antidepre	nary dated 1/14/16, indicated essant medications, blood s, and other medications.			
	review revealed the	(both paper and electronic) last monthly medication om the pharmacist was 5.			
	pharmacist indicate review information v based system, and facility EHR [electro Care (PCC)] he wor (DON) a copy of the and the recommend	0 p.m. the consultant d the monthly medication was produced on a pharmacy he made entries into the nic health record, Point Click uld give the director of nursing e list of residents he had seen dation he had made would be			
	system. The CP dic the facility EHR was individual resident ' provided a copy of pharmacist. Neither	riate physician from the PCC I not know why his entries into s not available within each s medical record. The DON each visit by the consultant was able to explain why the t available in the resident ' s 1/14/16.			
	pharmacist was inte completed the phar with the DNS on an would give the DNS completed fax to be pharmacist indicate the DNS on the rec	p.m. the facility's consultant erviewed verified after he macy reviews he would confer y recommendations and the documentation and the e sent to the provider. The d that he would follow up with ommendations and resolution . If the recommendations had			

Facility ID: 00943

If continuation sheet Page 83 of 84

		AND HUMAN SERVICES				FORM	03/02/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245148	B. WING			01/	14/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ST	LOUIS PARK PLAZA			201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	computer he used of then go into Point C recommendation/s in PCC and if no reco simply click no reco the record and go of In addition, the phar look at the following resident's records: - Are medications a - Vital signs, - Progress Notes, - Any adverse effect resident was receive - Review at target b have been on their During the interview indicated he did not pharmacy reviews i PCC and verified he pharmacy reviews a showing on the com The resident's med necessary monthly The facility's Conten dated last revised of paper or electronic Record shall contai	during the reviews and would Click Care (PCC) and if he had he would enter the information commendation/s he would ommendations and get out of on to the next record. rmacist indicated he would g when reviewing the appropriate for the resident(s), ets of the medications the ring, and behaviors and how long they medications. with the pharmacist, he t know what happened to in the facility computer system, e had not created the at the time they were all nputer as he was sleeping. ical lacked evidence of the medication reviews. nt of the Medical Record policy on 6/3/14, indicated "whether in format, the Resident Medical n at least the following ing "Consultant Pharmacist		14			

Facility ID: 00943

If continuation sheet Page 84 of 84

		AND HUMAN SERVICES & MEDICAID SERVICES		F5148024	FORM	: 02/08/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245148	B. WING		01	/12/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ST	LOUIS PARK PLAZA		3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	кc	000		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm marshal Division or of this survey, Gold was found not in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		EDOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY		EPOC	1	
	Healthcare Fire Ins State Fire Marshal 444 Cedar St., Suit St. Paul, MN 55101	Division e 145				
	By email to:					
	director's or provie	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 02/04/201

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING	COMPLETED		
		245148	B. WING		01/12/2016
	PROVIDER OR SUPPLIER	LOUIS PARK PLAZA	3	TREET ADDRESS, CITY, STATE, ZIP CODE 201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
K 000	DEFICIENCY MUS	tate.mn.us, n@state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE	K 000		
	FOLLOWING INFORMATION:1. A description of what has been, or will be, done to correct the deficiency.2. The actual, or proposed, completion date.				
	3. The name and/o responsible for cor	r title of the person rection and monitoring to ence of the deficiency.			
	building with no ba constructed at 2 dir building was constructed determined to be o 1972 a two- story a East Wing and det construction. Beca the 1 addition are o	er St. Louis Park is a 3-story sement. The building was fferent times The original ructed in 1966 and was f Type II (222) construction. In addition was constructed to the ermined to be of Type II (222) use the original building and of the same type of acility was surveyed as one			
	throughout. The far with smoke detecti open to the corrido automatic fire depa	v fire sprinkler protected cility has a fire alarm system on in the corridors and spaces rs that is monitored for artment notification. The facility 08 beds and had a census of he survey.			i ji
K 054	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD	K 054		2/23/16

ND BLAN OF CODDECTION			1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY
			A. BUILDI	INGU	1 - MAIN BUILDING UT		
	245148					01/	12/2016
IAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
OLDEN	LIVINGCENTER - S	T LOUIS PARK PLAZA			AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETI DATE
K 054 SS=F	activating door hole maintained, inspec	age 2 detectors, including those d-open devices, are approved, ted and tested in accordance irer's specifications. 9.6.1.3	κo)54			
	Based on staff inte documentation, the conducting sensitiv detectors on the fir with NFPA 72 (99), practice could affect Findings include: On facility tour betw 1/12/2016, a review alarm test docume failed to conducted each smoke detect	is not met as evidenced by: erview and review of available e facility has not been vity testing of the smoke re alarm system in accordance Sec. 7-3.2.1. This deficient ct all 178 residents. ween 9:00 AM and 3:00 PM on w of the facility's available fire ntation revealed that the facility I the required sensitivity test of tor, the last smoke detector conducted in 2013.	/		 a. Facility has arranged for requisensitivity testing of each smoke b. Facility has service agreement completing required testing of firesystem. c. Requirements for sensitivity to been reviewed by Maintenance. d. ED or designee will complete audit for required sensitivity testing results will be reviewed at QAPI and frequency of audits adjusted according to results. 	detector. ts for e alarm esting has quarterly ng. Audit meeting	
	This deficient practice was verified by the Maintenance Supervisor.						
		-					

PRINTED: 02/08/2016



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted January 29, 2016

Mr. Timothy Johnson, Administrator Golden LivingCenter - St Louis Park Plaza 3201 Virginia Avenue South Saint Louis Park, MN 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5148025

Dear Mr. Johnson:

The above facility was surveyed on January 11, 2016 through January 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5148155 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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 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,

Golden LivingCenter - St Louis Park Plaza January 29, 2016 Page 2

"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 contact Ms. Derfus at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kumala Piske Downing

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

Minnesc	ta Department of He	ealth			-	-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00943	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PI	GINIA AVENU DUIS PARK, I			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depu- Determination of wit corrected requires requirements of the number and MN Ru When a rule contait comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	corrected. You may request a that may result from orders provided tha the Department wit notice of assessme INITIAL COMMEN ^T You have agreed to receipt of State lice the Minnesota Dep	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. TS: participate in the electronic insure orders consistent with artment of Health				
	http://www.health.s	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota				
Minnesota D	epartment of Health	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE		(X6) DATE
	ically Signed	SENSOFT EIER HEI NESENTATIVES SIG		IIILC		02/04/16

STATE FORM

6899

If continuation sheet 1 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/14/2016	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		01/	14/2010
	LIVINGCENTER - ST	3201 VIR	GINIA AVENU	E SOUTH		
		SAINT L	OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC) CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departn On January 11th,12 surveyors of this De above provider and orders are issued. electronic plan of c	2th,13th, and 14th, 2016, epartment's staff, visited the I the following correction Please indicate in your orrection that you have ers, and identify the date wher				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	January 14,2016, a	tandard survey completed on in investigation of complaint was conducted and found to				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00943		B. WING		01/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST		IGINIA AVENU OUIS PARK, I			
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			2/23/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the cor assessment. The of must include the in	of plan of care. The n of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to dev residents (R187) w	ent is not met as evidenced and document review, the elop care plan for 1 of 2 ho used a blood thinner and essary medications.		corrected		
	Findings include:					
	asked about her me knew most of her n did and told survey	20 p.m. when approached and edications, R187 stated she nedications. R187 stated she or she had received the six years and had started				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
	00943		B. WING		01/	01/14/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST GINIA AVENUE OUIS PARK, MI	ESOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE	
2 560	 when she was preg she was aware of t Lovenox (used to p (DVT) which can le bruising and stated bruised. R187 state administration and the past. Review of R187's I treatment and med did not indicate ant monitoring includin bruising. Review of the Nurs 1/14/16, revealed r addressed even the verbalize how she R187's diagnoses i other venous throm (primary) hypertens history of pulmonar (current) use of ant Electronic Medicati 2015. Review of the care R187 had "Altered related" however potential for bruisin therapy identified/a The Physician Orde R187 had an order (Lovenox) solution 	gnant at the time. R187 stated he side effect from using the prevent deep vein thrombosis ead to blood clots) such as I her abdomen was much ed the staff did all the her husband did help her in December 2015 to 1/14/16, lication administration records ticoagulant side effect g risk for bleeding and eses notes dated 12/20/15 to no bruises had not been ough resident was able to had sustained them. included personal history of nbosis and embolism, essentia sion, atrial fibrillation, personal ry embolism and long term ticoagulants obtained from the ion Record dated January plan dated 4/23/15, revealed skin integrity non pressure , did not indicate R187 had the ng related to anticoagulation uddressed in the care plan. er dated 10/5/15, indicated for Enoxaparin Sodium milligram/milliliter (mg/ml) 100 y every 12 hours for	1				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	LIVINGCENTER - S	T LOUIS PARK PI	GINIA AVENU			
		SAINTL	OUIS PARK, M			
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 4	2 560			
	(RN)-C stated usua on a blood thinner the facility had a st electronic medicati (EMAR) for the nur stated usually there staff were already s in the EMAR. -At 1:00 p.m. RN-E be" when asked if a be developed wher thinner such as R1 care plan and even	56 p.m. registered nurse ally for any resident who was such as Coumadin or Lovenox andard order put in the on administration record rses to check every shift. RN-C e was no care plan for it as the signing off on the side effects 8 approached stated "It should a care plan was supposed to n someone was on a blood 87. RN-B verified the current n previous cares plans had not otential for bruising and	;			
	services (DNS) sta to have been devel) p.m. the director of nursing ted a care plan was supposed loped for R187 if resident had using a blood thinner.				
	01/22/2015, directe Complete an Ir within 24 hours foll anticoagulation the Integrate interv comprehensive pla interdisciplinary can the policy indicated satisfactory monito plan of care was to	mmediate Plan of Care (IPOC) owing initiation of				
	director of nursing inservice nursing s	THOD OF CORRECTION: The (DON) or designee could taff to the development of a re plan, then audit to ensure				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
00943		B. WING		01/14/2016	
IAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
OLDEN	LIVINGCENTER - ST	LOUIS PARK PI	GINIA AVEN DUIS PARK,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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 APPROPRIAT DEFICIENCY)	
2 560	Continued From pa	ige 5	2 560		
	compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		2/23/16
		omprehensive plan of care I personnel involved in the t.			
	by: Based on observat review, the facility f 3 of 5 residents (R	ent is not met as evidenced ion, interview, and document ailed to follow the care plan for 13, R153, R181) reviewed for incontinence and for 2 of 3 181) for reviewed		corrected	
	Findings include:				
	a.m. Upon entering smell was noted but the time. At 7:17 a. resident had been a day nursing assista assisted the reside a.m. During continu R13 was not toilete	eserved on 1/14/16, at 7:16 R13's room strong urine it R13 was not in the room at m. when asked what time assisted to get ready for the int (NA)-B stated he had nt as R13 had been up at 6:45 yous observation to 10:05 a.m. d or offered to be checked and burs and 15 minutes.			
	On 1/14/15. at 10:1	5 a.m. NA-B acknowledged			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
	00943		B. WING		01/	14/2016
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
	LIVINGCENTER - ST	3201 VIB	GINIA AVENUE			
	EIVINGCENTER - ST	SAINT LO	OUIS PARK, M	N 55426		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 6	2 565			
	over one hour and resident had last be NA-B stated "We at the residents in the transfers because t and some are comb the room for half ho another resident in go now. Someone of are under staffed at aides with heavy ca even take a 15 min will be lunch here c -At 10:26 a.m. LPN follow the plan of ca toilet the resident til would have expected was running late to	then toileted timely and was 15 minutes from when even checked and changed. The under staffed and some of unit need two staff with they use the transfer machine bative and if two aides go into our they is no way I can tell the middle of cares I have to can point a finger at me but we and for 27 residents for two ares it's impossible. I have not ute break and in 20 minutes oming and I am shaking." stated NA's were supposed to are and were supposed to mely. LPN-B further stated she ed NA-B to report to her he toilet and resident had ould have attempted to nt as she did.				
	Care Area Assessmi identified resident w bladder, was at risk tract infections and plan dated 11/13/14 functional incontine Care plan directed one to toilet. Use by protection and to to and as needed. R13's comprehensi	tinence indwelling catheter nent (CAA) dated 10/14/15, vas incontinent of bowel and t for urine body odor, urinary skin breakdown. R13's care 4, identified resident had a nce of bladder and bowel. staff to provide assistance of riefs/pads for incontinence illet resident every two hours ive assessment dated 1/4/16, incontinent of bowel and				
	bladder and directe	d staff to check and assist d as needed as resident				

Minneso	ta Department of He	ealth				APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
			A. BUILDING:			
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOI DEN	I LIVINGCENTER - S		GINIA AVENU			
		SAINTLO	OUIS PARK, M	IN 55426		1
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	age 7	2 565			
	until 10:35 a.m. am least three hours. A approached R153 and asked R153 if be changed. (NA-E "No." At 10:19 a.m after asking permis NA-D transferred F with mechanical lift urine present wher was present and ve washed hands, put R153's pants. NA-E incontinence brief. with urine and RN- saturated. NA-D wi incontinence wipe. area from back to f incontinence brief. The Alteration in El Bladder, Incontiner plan dated 6/29/15 change resident ev Care plan dated 11 physical functioning impairment, and m goals were that R1	d on 1/13/16, from 7:00 a.m. d R153 was not toileted for at At 10:09 a.m. NA-E in day room during activities would like to go to room and asked quietly) R153 said, . NA-B brought R153 to room asion. At 10:25 a.m. NA-B and R153 from wheel chair to bed t. There was a strong odor of a R153 was lying in bed. RN-D erified the urine odor. NA-B to ngloves, and removed B removed R153's The product was saturated D verified the brief was iped R153's bottom with an Brown stool observed on NA-D washed R153's peri front, then applied new				
	personal hygiene, I indicated R153 had ADL assistance de The undated nursir	ng assistant assignment sheet				
nesota Da	for R153 instructed	I staff that R153 was				
ATE FORM	-		6899 70	6C411	If continua	tion sheet 8 c

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00943			01/	14/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S			
OLDEN	LIVINGCENTER - S		OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	incontinent of bowel and bladder and was to be checked and change every two hours. R181 was observed on 1/13/16, from 7:00 a.m. until 8:55 a.m. at 7:00 a.m. R181 was sitting in dining room. R181 was wearing a brown patterned boat neck shirt and a red infinity scarf. During observation of incontinence care on 1/13/16, from 8:46 a.m. until 8:55 a.m. NA-D and NA-E transferred R181 from wheelchair to bed using a mechanical lift. NA-D applied gloves and removed R181's pants and opened incontinence brief. The peri area observed to be red from front to approximately four centimeter cm above the rectum. When NA-D touched skin, area blanched. The incontinent brief was completely saturated with urine. NA-D verified brief was saturated with urine.					
un dir pa Du 1/1 NA us rer bri to rec bla sa						
	R181 had functiona	nt dated 12/22/15, indicated al urinary incontinence and was toileting or retraining program tia and immobility.				
	was functionally inc	d 1/12/16, indicated resident continent of bowel and bladder o check and change R181 eeded.				
	R181 instructed sta	ssistant assignment sheet for aff that R181 was incontinent cked and change every two ed.				
	said, "[R153] was o started at about 6:4 7:00 a.m. [R153] w	n 1/13/16, at 9:49 a.m. NA-B our third resident to get up. We 45 a.m. and were done about vas taken for activities and had refused that morning. [R181]				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	ELOUIS PARK PI	IGINIA AVENU OUIS PARK, M			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	age 9	2 565			
	[R181] is laid down then at 11:00 a.m. every two hours for [R181] does not ref - At 9:56 a.m. licen said R153 was to b and check and cha could also ask to b acknowledged R15 two hours. LPN-B s someone take care be checked and ch - At 10:11 a.m. NA- around 6:30 a.m. - At 10:13 a.m. reg R153 was to be rep offered to be chang - At 2:47 p.m. nursi was working a doul we are short staffed assisting residents repositioned NA-B the every two hours changing because it takes you 15 to 3 the next one. How - At 2:55 p.m. NA-E to do the reposition hours. We are so b best." NA-D said, "I to back, but I wiped front. I am not sure - At 9:22 a.m. the d (DNS) said, "I exper regarding incontine check and change their care plans." R	sed practical nurse (LPN)-B be repositioned every two hours inge every two hours. R153 e changed. LPN-B 53 had not been toileted in over stated LPN-B would have e of it right away. R181 was to hange every two hours. -E stated we got R153 up istered nurse (RN)-D stated positioned every two hours and ged every two hours. ing assistant (NA)-B stated ble. NA-B stated, "Right now d." When asked about to the bathroom and to be said, "You cannot always do s turning and repositioning and you need two people and ther 0 minutes and you need to do				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	······	COM	PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOLDEN	LIVINGCENTER - S		GINIA AVENU DUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 10	2 565			
	until 10:35 a.m. for - At 7:00 a.m. R153 mechanical lift sling - At 9:05 a.m. R153 sleeping at table, p a.m. - At 9:30 a.m. Alzh wheeled R153 to d - At 9:49 a.m. R153 - At 10:09 a.m. NA room during activit like to go to room a quietly) R153 said, - At 10:19 a.m. NA asking permission. - At 10:25 a.m. R13 area to the coccyx. immediately above The coccyx had an (cm.) x 1.5 cm non	3 sitting in dining room. A g under R153. 3 sitting in dining room, oosition unchanged since 7:00 eimer's care director-B ay room. 3 sitting in activity room. -E approached R153 in day ies and asked R153 if would and be changed. (NA-E asked "No." -B brought R153 to room after				
	"CAA triggered for CVA [stroke] with w requires staff assis see MDS ADL/con	r CAA dated 6/26/15, indicated pressure r/t Hx [history of] of veakness, res. is incontinent, tance with bed mobility/cares, tinence coding. Res. [resident] ire, infection, pain and overall				
	ulcer present to rig tissue injury. Ulcera Interventions incluer resident was in bee	sed 1/12/16, indicated pressure ht heel - suspected deep ation to left lateral malleolus. ded heel boots to be worn while d and had specialized boots in wheelchair, provided by				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00943	B. WING		01/	01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-		
GOLDEN	I LIVINGCENTER - ST	ELOHIS PARK PI	GINIA AVENU OUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 11	2 565				
	therapy, float heels hours.	while in bed, offload every two					
	until 8:55 a.m. for r - At 7:00 a.m. R18 Mechanical lift sling - At 7:45 a.m. NA-E R181 - At 7:56 a.m. brea and NA-B started to - At 8:10 a.m. spee at the dining room - At 8:46 a.m. NA-E room and took to re transferred R181 fr mechanical lift. The red from front to ap cm above the rectu	1 was sitting in dining room. g under R181. 3 sat down and talked with kfast was delivered to R181 o feed R181. ch therapy working with R181					
	indicated "CAA trig incontinence. Res i UTI. Proceed to ca and provide care P [medical doctor] NF	e CAA dated 12/24/15, gered dr/t (sic) urine is at risk for skin break down, re plan to ensure staff aware RN [as needed]. Update MD P [nurse practitioner] PRN."					
	to turn and repositi	nitiated on 1/6/16, directed staft on R181 every two hours.					
	said R153 was the started at about 6:4 7:00 a.m. [R153] w been asked or refu our first resident to	1/13/16, at 9:49 a.m. NA-B third resident to get up. "We 45 a.m. and were done about as taken for activities, has not sed this morning. [R181] was get up at 6:10 a.m. [R181] is nged after breakfast then at 11					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION		E SURVEY PLETED
		DENTIFICATION NONDER.	A. BUILDING: _		001	
		00943	B. WING		01/	14/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - ST		IGINIA AVENUI OUIS PARK, M			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ige 12	2 565			
	changing and reposite refuse toileting." - At 9:56 a.m. LPN- repositioned every a acknowledged R18 two hours. - At 10:11 a.m. NA- around 6:30 a.m." - At 10:13 a.m. RN- repositioned every a state of the event of the even	 at was to be repositioned every E stated, "We got [R153] up D stated R153 was to be two hours. "If it does not occurn issues, skin breakdown thrombosis (clots) or D stated R181 was to be two hours. "If it does not occurn issues, skin breakdown thrombosis (clots) or D stated R181 was to be two hours. "If it does not occurn issues, skin breakdown thrombosis (clots) or B stated they were working a d, "Right now we are short ed about assisting residents to the said, "You cannot always purs turning and repositioning use you need two people and 5 to 30 minutes and you need How can you fix it?" D said, "I don't always have sitioning and toileting every so busy right now. We do our THOD OF CORRECTION: sing or designee could arding how to correctly nt plan of care, and then audit 				
	(21) days.					

	ta Department of He	ealth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		00943	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	ELOHIS PARK PI	GINIA AVENUI DUIS PARK, M			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETE DATE
2 625	Continued From pa	age 13	2 625			
2 625	MN Rule 4658.045 Contents; In Gener	0 Subp. 1 A-P Clinical Record al	2 625			2/23/16
	record, including n A. the condition admission; B. temperature pressure, according subpart 2, item C. the resident according to part 4 D. the resident and attitudes; E. observations interventions provid responsible for care of the part 4	's height and weight, 658.0520, subpart 2, item J; 's general condition, actions, s, assessments, and ded by all disciplines resident, with the exception of				
	behavior, orientatio nursing home, G. date, time, o method of administ					
	H. a report of a three months prior in part 4658.08 I. reports of lat	nistered the medication; a tuberculin test within the to admission, as described 10; poratory examinations; mes of all treatments and				
	K. dates and tir health care practitio L. visits to clini	cs or hospitals; or instructions relative to the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/14/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, GINIA AVEN DUIS PARK,			
(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 COMPLET	
2 625	habits or appetite; O. pertinent fa resident's general o P. results of th resident assessme	to the resident's sleeping ctors regarding changes in the				
	by: Based on interview facility failed to ma were complete for R108, R151, R187	ent is not met as evidenced and document review, the intain accurate medical records 10 of 10 residents (R3, R211, , R42, R126, R154, R164, r monthly pharmacist reviews.	5	corrected		
	Findings include: R3's Admission Record dated printed on 1/14/16, indicated R3 was admitted to the facility on 6/1/15, with diagnoses including end stage renal disease, type 2 diabetes mellitus and Down's syndrome.					
	review revealed no medication regime The Physician's Or R3 took pain medic	d (both paper and electronic) record of the monthly n review's from the pharmacist ders dated 11/23/15, indicated cations, antihypertensive ntipsychotic medications.				
	director of nursing medical record did regimen review's s expect the monthly readily available fo	roximately 1:10 p.m. the services (DNS) verified R3's not contain any medication ince admission, and would pharmacist reviews to be r review in resident's individual				
nnesota De ATE FORM	epartment of Health VI		6899	76C411	If continuation sheet 15 of	

	ta Department of H	ealth (X1) PROVIDER/SUPPLIER/CLIA				E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		00943	B. WING		01/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S		GINIA AVENU			
(X4) ID	SUMMABY ST		OUIS PARK, M	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET
2 625	Continued From pa	age 15	2 625			
	medical record.					
	1/14/16, indicated admitted to the fac	Record dated printed on R211 was most recently ility on 8/7/15, with diagnoses ective disorder, delusional ety disorder.				
	indicated took pair	Orders dated 10/25/15, medications, antianxiety sychotic medications and other				
	review revealed th	d (both paper and electronic) e last monthly medication rom the pharmacist was 15.				
	R211's record and consultant review	5 a.m. the DNS reviewed confirmed the last pharmacy was from 6/4/15, and stated e consultant pharmacist for				
	information appear record for R211's r the electronic char - Effective date: 8/3 - Effective date: 9/3 - Effective date: 10 - Effective date: 11	30 p.m. the following red in the electronic medical nissing pharmacy reviews in t: 31/15, created on 1/14/15; 30/15, created on 1/14/15; /30/15, created on 1/14/15; /30/15, created on 1/14/15; /31/15, created on 1/14/16;				
	dated 11/9/15, incl hypertension, anxi disease.	Minimum Data Set (MDS) uded diagnoses of ety, fibromyalgia, and lung				
nnesota D ATE FORI	epartment of Health M		6899 7	6C411	If continuati	on sheet 16 c

	IT OF DEFICIENCIES OF CORRECTION			CONSTRUCTION		E SURVEY PLETED
		00943	B. WING	B. WING		14/2016
	PROVIDER OR SUPPLIER	3201 VIE	DRESS, CITY, ST			
GOLDEN	I LIVINGCENTER - S		OUIS PARK, M			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	age 16	2 625			
	10/4/13. The medic taking cyclobenzap fibromyalgia, Fenta chronic pain, fluoxe olanzapine (an anti	nission to the facility was cal record indicated R108 was orine (a muscle relaxant) for anyl patch every 72 hours for etine for depression, i-psychotic) for major entin for neuropathic pain, and				
	2015 were not avail	onthly reviews and for November and December ilable in the electronic health facility could not explain why				
	12/16/15, included hypertension, diabe dementia, and psyc	inimum Data Set (MDS) dated the following diagnoses of etes mellitus, hyperlipidemia, chotic disorder other than 51 had an admission date of				
	record of a pharma 6/5/15, and there w included in the pap indicated resident	edications, antipsychotic and				
	director of nursing about the whereab reviews for R151 a she was going to c	roximately 1:00 p.m. the services (DNS) was queried outs of the monthly pharmacy fter 6/5/15. The DNS indicated ontact the facility's consultant se she could not find any after 6/5/15.				

Minneso	ta Department of H	ealth			FURIV	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00943	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S	T LOHIS PARK PI	GINIA AVENU			
		SAINT LO	OUIS PARK, N			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	age 17	2 625			
	information appear record for R151's r the electronic char - 9/29/15 review da p.m. - 10/30/15 review o p.m. - 11/30/15 review o p.m.	30 p.m. the following red in the electronic medical nissing pharmacy reviews in t: ate, created 1/13/16 at 12:26 date, created 1/13/16 at 12:27 date, created 1/13/16 at 12:28 date, created 1/13/16 at 12:29				
	other venous throm (primary) hypertens history of pulmona (current) use of an hypercholesteroler edema, hypomagn reflux disease with generalized anxiety electronic medication The medical record	included personal history of nbosis and embolism, essentia sion, atrial fibrillation, personal ry embolism, long term ticoagulants, nia, iron deficiency anemia, esemia, gastro-esophageal out esophagitis and y disorder obtained from the on record dated January 2015. d (both paper and electronic) o record of the monthly				
	medication regime The Physician's Or R3 took pain medic thinner, antihyperte	n review's from the pharmacist ders dated 11/23/15, indicated cations, antianxiety, blood				
	interviewing the co following information medical record for reviews in the elect - Effective date: 7/3	0 p.m. while surveyors were nsultant pharmacist the on appeared in the electronic R187's missing pharmacy tronic chart: 31/15, created on 1/14/16				
nesota D ATE FORI	epartment of Health		6899 7	6C411	If continuet	on sheet 18 o

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
		00943	B. WING			01/14/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	IATE, ZIP CODE			
OLDEN	I LIVINGCENTER - ST	ELOHIS PARK PI	RGINIA AVENUI OUIS PARK, M				
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 625	Continued From pa	age 18	2 625				
	 Effective date: 9/3 Effective date: 10 Effective date: 11, 	31/15, created on 1/14/16; 30/15, created on 1/14/16; /30/15, created on 1/14/16; /30/15, created on 1/14/16; /31/15, created on 1/14/16;					
	disorder, anxiety di depressive disorde	cluding schizoaffective sorder, dementia, major r, hypertension, diabetes losis obtained from admission /16.					
	R42 took pain med medications, antips diabetes oral medic medications among (both paper and ele	Orders dated 1/14/16, indicated lications, antianxiety sychotic, an antidepressant, cations including and insulin g others. The medical record ectronic) review revealed no nly medication regimen harmacist.	b				
	interviewing the co following information medical record for reviews in the elect - Effective date: 7/3 - Effective date: 8/3 - Effective date: 10 - Effective date: 11	 p.m. while surveyors were nsultant pharmacist the on appeared in the electronic R187's missing pharmacy tronic chart: 81/15, created on 1/14/16; 80/15, created on 1/14/16; /30/15, created on 1/14/16; /30/15, created on 1/14/16; /31/15, created on 1/14/16; 					
	diabetes mellitus, h chronic kidney dise	included hypertension, type II hyperlipidemia, heart failure, ease stage four and chest pain ission record printed 1/14/16.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00943	B. WING		01/	14/2016
	PROVIDER OR SUPPLIER		ADDRESS, CITY, S RGINIA AVENU LOUIS PARK, M	E SOUTH	·	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	age 19	2 625			
	indicated R126 too	orders dated 1/11/16, ok multiple antihypertensive osulin medications among				
	review revealed th	d (both paper and electronic) e last monthly medication rom the pharmacist was 15.				
	pharmacist stated documentation from no documentation electronic resident reviews had been pharmacist stated documents and did	B p.m. the consultant and showed surveyor his m all the past reviews howeve was in either the paper or medical record to justify the done monthly. The consultant he had not created the d not have explanation how ing up all of a sudden.				
	disorder, post-trau vitamin D deficient pain, acute emboli veins of lower extra insomnia, hyperter that causes muscle	included major depressive matic stress disorder diabetes cy, anxiety disorder, chronic sm on thrombosis of deep emity (blood clot in leg), nsion, fibromyalgia (a disorder e pain and fatigue), chronic nary disease obtained from dated 1/14/16.				
	consultant pharma Review in the char	d 9/30/14. There were no cist's Medication Regimen t on 1/13/16 recorded by the / 2015, through January 13,				
	R154 took pain me	mary dated 1/14/16, indicated edications, antianxiety I thinner medications, and othe				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00943	B. WING		01/	01/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - S		GINIA AVENUI OUIS PARK, M				
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 625	Continued From pa	age 20	2 625				
	medications.						
	health record show R154's missing phi- electronic chart: - Effective date: 8/3 - Effective date: 9/3 - Effective date: 10 - Effective date: 11 - Effective date: 12 R164's diagnoses major depressive of obstructive pulmon Admission Record R164's Order Sum	0 p.m. review of electronic ved Pharmacy Review for armacy reviews in the 31/15, created on 1/14/15; 30/15, created on 1/14/15; /30/15, created on 1/14/15; /30/15, created on 1/14/15; /31/15, created on 1/14/16; included subdural hemorrhage lisorder, hypertension, chronic ary disease obtained from dated 1/14/16. mary dated 1/14/16, indicated edications, and other					
	consultant pharma Reviews recorded	8/9/14. There were no cist's Medication Regimen by the pharmacist for July ember 2015, in R164's chart.					
	disorder, dementia	included major depressive , hypertension, and atrial from Admission Record dated					
	consultant pharma Review recorded b	d 4/21/15. There were no cist's Medication Regimen y the pharmacist for July 2015 2015, in R103's chart.	,				
	R103 took antidep	mary dated 1/14/16, indicated ressant medications, blood s, and other medications.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00943	B. WING		01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	TI OLIIS PARK PI	GINIA AVENU DUIS PARK, M			
(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	(X5) COMPLET DATE
2 625	Continued From pa	age 21	2 625			
	review revealed the	d (both paper and electronic) e last monthly medication rom the pharmacist was 5.				
	pharmacist indicate review information based system, and facility EHR [electro Care (PCC)] he wo (DON) a copy of th and the recommen faxed to the approp system. The CP did the facility EHR wa individual resident provided a copy of pharmacist. Neithe	30 p.m. the consultant ed the monthly medication was produced on a pharmacy I he made entries into the poinc health record, Point Click ould give the director of nursing e list of residents he had seen idation he had made would be priate physician from the PCC d not know why his entries into is not available within each 's medical record. The DON each visit by the consultant ir was able to explain why the available in the resident 's il 1/14/16.				
	pharmacist was int completed the phar with the DNS on ar would give the DNS completed fax to be pharmacist indicate the DNS on the red the following month not been acted on recommendation a pharmacist indicate computer he used then go into Point () p.m. the facility's consultant erviewed verified after he rmacy reviews he would confer- ny recommendations and S the documentation and the e sent to the provider. The ed that he would follow up with commendations and resolution h. If the recommendations had he would reissue the nd talk to the DNS. The ed he had his my own during the reviews and would Click Care (PCC) and if he had				
	in PCC and if no re simply click no reco	he would enter the information ecommendation/s he would ommendations and get out of on to the next record.				

STATEMEN	ta Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
	PROVIDER OR SUPPLIER	STREET AL 3201 VIR	GINIA AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SAINT LO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	DUIS PARK, M ID PREFIX TAG	IN 55426 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 625	Continued From pa	age 22	2 625			
	look at the followin resident's records: - Are medications - Vital signs, - Progress Notes, - Any adverse effe resident was recei - Review at target have been on their During the intervie indicated he did no pharmacy reviews PCC and verified h pharmacy reviews showing on the co The resident's med necessary monthly The facility's Conte dated last revised paper or electronic Record shall conta information", inclue Notes/Recomment The director of nur (s)could review an procedures related recommendations the medical record designee (s)could staff and develop a	appropriate for the resident(s), cts of the medications the ving, and behaviors and how long they medications. w with the pharmacist, he of know what happened to in the facility computer system he had not created the at the time they were all mputer as he was sleeping. dical lacked evidence of the medication reviews. ent of the Medical Record policy on 6/3/14, indicated "whether in c format, the Resident Medical in at least the following ding "Consultant Pharmacist	,			
	(21) days.	R CORRECTION: Twenty-one				
nnesota De ATE FORM	epartment of Health M		6899 7	6C411	If continuati	on sheet 23 c

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00943	B. WING		01/14/2016
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
OLDEN	I LIVINGCENTER - ST	I OLIIS PARK PI	GINIA AVEN DUIS PARK,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 APPROPRIAT DEFICIENCY)	
2 800	Staffing requirement Subpart 1. Staffing home must have on number of qualified registered nurses, I nursing assistants of residents at all nurse in all buildings if mo- involved. This inclu- and vacation replace This MN Requirement by: Based on observate review, the facility f staffing to ensure re assistance with car reviewed for dignified facility failed to pro- activities of daily liv (R153) who was inter- for 2 of 3 residents potential skin break (R13, R153, R181) incontinence. In ad (R166, R183, R125- 13 of 13 staff memi- LPN-E, NA-F, NA-E and expressed com- to insufficient staffin	requirements. A nursing n duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements. ent is not met as evidenced ion, interview, and document ailed to provide adequate esidents received the required es for 1 of 1 resident (R181) ed care and services, the vide timely assistance with ing (ADLs) for 1 of 4 resident	2 800	corrected	2/23/16
	currently resided in Findings include:	the facility.			
	Assessed resident > Refer to F241: Th	needs not met: ne facility failed to provide			

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/	14/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - S	T I OHIS PARK PI	GINIA AVENU OUIS PARK, M			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 800	Continued From pa	age 24	2 800			
		or 1 of 1 resident (R181) sisted with eating by staff who g R181.				
	care plan for 3 of 4 reviewed for bowe	he facility failed to follow the residents (R13, R153, R181) and bladder incontinence and (R153, R181) for reviewed				
	timely assistance v	he facility failed to provide with activities of daily living esident (R153) who was I.				
	timely repositioning	he facility failed to provide g for 2 of 3 residents (R153, r potential skin breakdown.				
	timely assistance v	he facility failed to provide with incontinence care for 3 of 4 53, R181) reviewed for urinary				
	10/7/15, indicated required extensive staff with personal with toileting, dress	linimum Data Set (MDS) dated R166 had intact cognition physical assistance of one hygiene and was independent sing, transfers and bed mobility S indicated R166 used both a				
	asked if he felt the to make sure you g need without havin stated, "Sometime	9 p.m. during interview when re was enough staff available get the care and assistance you to wait a long time resident s the staff ignore you and when or a long time and sometimes I				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00943	B. WING		01/	14/2016
	PROVIDER OR SUPPLIER	T LOUIS PARK PL 3201 VIE	DDRESS, CITY, ST CINIA AVENUI OUIS PARK, M	E SOUTH	·	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa just need ice."	age 25	2 800			
	cognition was mod	IDS dated 10/8/15, indicated lerately impaired and was Ill activities of daily living				
	asked if he felt the to make sure you on need without havin stated, "They are p	2 p.m. during interview when re was enough staff available get the care and assistance you g to wait a long time resident beople here who have to wait I this people are calling for a	L			
	cognition was intac physical assistance mobility, dressing,	IDS dated 11/10/15, indicated ct and required extensive e of one to two staff with bed toileting and personal hygiene. S indicated R125 used a pility.				
	asked if he felt the to make sure you o need without havin	5 p.m. during interview when re was enough staff available get the care and assistance you g to wait a long time resident tle before they come an hour onger."	L			
	cognition was intac extensive physical dressing, toileting, hygiene. In addition	IDS dated 12/10/15, indicated et and R187 required limited to assistance of one staff with transfers and personal n, the MDS indicated R187 for mobility and had no				

Minnesc	ta Department of H	ealth			FONIX	APPROVEL
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
				·		
		00943	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S		GINIA AVEN DUIS PARK,			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	age 26	2 800			
	asked if he felt the to make sure you g need without havin stated, "I have had from waiting for sta in a pad and I don was able to transfe had to call them wi	9 p.m. during interview when re was enough staff available get the care and assistance you g to wait a long time resident plenty of accidents right now aff to assist me. They have me ' t like them. Before my fall, I er myself not anymore. I have th my phone I don ' t hesitate. ad one aide for 30 residents				
	cognition was intac extensive physical dressing, toileting, hygiene. In addition used a wheelchair	IDS dated 11/7/15, indicated et and required limited to assistance of one staff with transfers and personal n, the MDS indicated R192 for mobility and had a n in range of motion on one xtremity.				
	asked if he felt the to make sure you g need without havin stated staff would g	p.m. during interview when re was enough staff available get the care and assistance you g to wait a long time resident go out of the room after light and would indicate were ance.				
	cognition was mod total to extensive p with dressing, toile hygiene. In addition	OS dated 11/4/15, indicated lerately impaired and required physical assistance of two staff ting, transfers and personal n, the MDS indicated R49 used obility and had no behaviors.				
linnocata		0 a.m. during interview when re was enough staff available				
TATE FOR			6899	76C411	If continuati	on sheet 27 of 8

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00943	B. WING		01/	14/2016	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	I LIVINGCENTER - S		GINIA AVENU				
		SAINT L	OUIS PARK, M	N 55426 PROVIDER'S PLAN OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 27	2 800				
	need without havin stated, "Weekends	get the care and assistance you g to wait a long time resident a, especially Sunday there is bund. I suppose it's my fault for					
	R3's quarterly minimum data set (MDS) indicated R3 was cognitively intact with a diagnosis of schizophrenia.						
	said they are under problem for me but especially in the ev concerns are share	n 1/13/16, at 12:30 p.m. R3 rstaffed here. "It is not a t it is for other residents rening or the nights. Staffing ed at resident council regularly. as why they could not open the ."					
	(LPN)-C stated the short staff and had and repositioning re assistance. LPN-C possible to finish th a pink slip to finish most of the times h needs and had to h	a.m. licensed practical nurse shift was usually sometimes to help the aides with turning esidents who required two indicated at times it was not ne workload and had to ask for the work. LPN-C further stated had to prioritize the resident have residents wait before their ed to which would be a while.	ł				
	stated the night shi other shifts when a was supposed to w would not be staffe the work. When as manageable RN-F	a.m. registered nurse (RN)-F ft was not short staff but on trained medication aide (TMA york with a nurse most times d and the nurse had to do all ked if the workload was stated "You can only do the yould ask the supervisor to					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PI	GINIA AVENUI OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 28	2 800			
		"t you do the best." RN-F those breaks were not taken had to wait.				
	During interview on 1/13/16, at 7:05 a.m. RN-F said, "I some times pick up shifts. I normally work p.m.'s [evening shift] but I picked up nights, last night and did a double." When asked, can you get your work done? RN-F replied, "Most of the time. Nights is easier. On p.m.'s on some units you need two nurses and a TMA but when you don't have a TMA you have to prioritize. Sometimes you have to leave things for the night shift. Paperwork. etc not meds, sometimes a treatment."					
	there were two nurs and the units share the units to pass m times if the unit was bumped off the car position was covere thought was good a lot more including in units were staffed w (NAs) and did not the and gave an examp room to assist a res transfer or complet	a.m. LPN-D stated usually ses for 2 South and 2 North d a TMA who went between edications. LPN-D stated at s short of an NA the TMA was t and instead at times this ed by a nurse which LPN-D as the nurse was able to do a nsulin's. LPN-D stated the with two nursing assistants hink the two NA's were enough ole if both the NA's went to a sident who required two staff to e care it was hard and was not her residents had to wait which the time.	D t			
	continuous observa station, several res to the LPN-E asked medications. LPN-E and told them she	a.m. to 9:10 a.m. during ations at the 2 South nursing idents were overheard walk up I for their morning E was heard re-direct residents would bring it to them. At 9:18 she was running behind with				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		СОМ	PLETED
		00943	B. WING		01/	14/2016
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	LIVINGCENTER - ST		GINIA AVENU			
		SAINT L	OUIS PARK, M	N 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 29	2 800			
	"I have not even sta on multiple times by rooms for assist wit unit to go get pain r located in 2 East w passing medication windows for some of turned red which in time window had ex On 1/13/16, at 9:28 sufficient nursing N get the workload do resident needs wer repositioning, turnir stated "We try but s it because it is so h requests can be a I them timely." -At 9:35 a.m. the di (DNS) was apprise working but was no pass going. DNS st process of hiring a DNS verified lookin window LPN-E was administration reco -At 9:48 a.m. R46 a overheard indicate for her medications resident request. -At 9:50 a.m. after of DNS attention, thre	a.m. when asked about A-F stated it was difficult to one. When asked if the e met timely such as ng and toileting needs NA-F sometimes we just can't get to reavy and the resident ' s ot and not being able to get to rector of nursing services d of observations of LPN-E t able to get the medication tated the facility was in the TMA for 2 South and 2 North. g into the computer screen s on the screen for medication				
	be red with all the r an untimely fashion - At 2:47 p.m. NA-E	reen windows were noted to nedications that were being in a. 3 stated was working a double. now we are short staffed."				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		00943	B. WING		01/	01/14/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - S	T I OHIS PARK PI	RGINIA AVENU OUIS PARK, M				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
2 800	Continued From pa	age 30	2 800				
	bathroom and to b can not always do and repositioning a need two people a minutes and you n can you fix it?" - At 2:55 p.m. NA-I time to do the repo two hours. We are best." On 1/14/16, at 10: under staffed and a unit need two staff use the transfer m combative and if tw half hour they is no in the middle of ca can point a finger a and for 27 resident cares it's impossib	t assisting residents to the e repositioned NA-B said, "You the every two hours turning and changing because you nd then it takes you 15 to 30 eed to do the next one. How D stated "I don't always have ositioning and toileting every so busy right now. We do our 15 a.m. NA-B stated "We are some of the residents in the with transfers because they achine and some are vo aides go into the room for o way I can tell another residen res I have to go now. Someone at me but we are under staffed ts for two aides with heavy le. I have not even taken a 15 in 20 minutes will be lunch here aking."	t				
	follows: Unit 1 North- Cens -Day shift- one nur three NA's -Evening shift- had for the building, two -Night shift- one SI two NA's (dependin staff). Unit 2 North-Censu -Day shift one nurs nurse assigned to	pattern was based on units as us 23 se manager (NM), two RN, and one nursing supervisor (SUP) o nurses, and three NA's. UP in building, one RN, and ng on acuity or admits can add us 29 & 2 South-Census 30 se assigned to 2 North and one 2 South, one TMA who went nd 2 South to assist with	Ł				

TATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943				14/2016
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			14/2010
	I LIVINGCENTER - ST	3201 VIB	GINIA AVENUE			
	EMINGCENTER - 5	SAINT L	OUIS PARK, M	N 55426		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 800	Continued From pa	age 31	2 800			
	 (total of 5 1/2) NA's cover people gettin bed. Evening shift- one and one nurse assi who went between with medication addit two and a half (tota hours. Night shift- one nu Unit 2 East- Censu Day shift one NM, Evening shift two nur Unit 2 East- Censu Day shift one NM, Evening shift two nur Unit ACU Census 2 as one unit). Day shift one NM a NA's with varying h Evening shift one nur NA's. Weekend supervise the nurse manager supervisors are hird vacant). The daily staffing s nearly unreadable, hand written in and planned staff (types staff. Example, on facility, 17 nurses v schedule and 15 w added after the schedule and 15 w 	three nurses, and six NA's nurses and one TMA or three A's ses and two NA 27 and AACU Census 25 (staff and one nurse on each side 5	f			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			E SURVEY PLETED
		00943			01/	01/14/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SAINT LY ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DUIS PARK, M	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 800	did a double from o LPN's did doubles of The facility DNS ar able to cover all sh changing the comp needed (if short a r hours, if short a NA increase nurse hou The DNS had acted twice in the past ye The DNS stated "si are getting filled, it's optimal staffing even The DNS revealed time equivalent = 8 open positions due nearby hospital. Th staff were leaving a street. The facility w the wage scale, and community. SUGGESTED MET director of nursing a current and ongoin if addition or reloca ensure all resident TIME PERIOD FOI (21) days. MN Rule 4658.052 Ulcers	lays to evenings and two from days to evenings. Ind staffer felt the facility was ifts budgeted hours by position of the staff when hurse increase TMA or NA and unable to fill than irs). I d as the evening supervisors par, with a census over 170. taff work really well and shifts is not easy and we are not at ery day." That 60% of RN/LPN FTE (full 0 hour per pay period) was to the hiring occurring at a ie NA open FTE was 58.1%, and citing more pay down the was in the process of reviewing d benchmarking with the THOD OF CORRECTION: The and/or designee could review g staffing patterns to evaluate tion of staff is needed to cares needs are met. R CORRECTION: Twenty-one 5 Subp. 3 Rehab - Pressure				2/23/16
		sores. Based on the ident assessment, the director				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00943	B. WING		01/	14/2016
PROVIDER OR SUPPLIER					
I LIVINGCENTER - S					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 33	2 900			
without pressure s pressure sores un condition demonst	sores does not develop ess the individual's clinical rates, and a physician				
receives necessal promote healing, p	ry treatment and services to revent infection, and prevent				
by: Based on observa review, the facility repositioning to 2 c	tion, interview, and document failed to provide timely of 3 residents (R153, R181)		corrected		
Findings include:					
until 10:35 a.m. for - At 7:00 a.m. R15 mechanical lift slin - At 9:05 a.m. R15	repositioning. 3 sitting in dining room. A g under R153. 3 sitting in dining room,				
- At 9:30 a.m. Alzh wheeled R153 to c - At 9:49 a.m. R15 - At 10:09 a.m. nur approached R153 and asked R153 if	lay room. 3 sitting in activity room. sing assistant (NA)-E in day room during activities would like to go to room and				
	LIVINGCENTER - S SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa of nursing services development of a r provides that: A. a resident wh without pressure so pressure sores unl condition demonst authenticates, that B. a resident w receives necessar promote healing, p new sores from de This MN Requirem by: Based on observat review, the facility repositioning to 2 c reviewed for poten Findings include: R153 was observe until 10:35 a.m. for - At 7:00 a.m. R15 mechanical lift slim - At 9:30 a.m. Alzh wheeled R153 to c - At 9:49 a.m. R15 and asked R153 if be changed. (NA-E	PROVIDER OR SUPPLIER 3201 VIE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to 2 of 3 residents (R153, R181) reviewed for potential skin breakdown. Findings include: R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. for repositioning. At 9:05 a.m. R153 sitting in dining room, sleeping at table, position unchanged since 7:00 a.m. At 9:30 a.m. Alzheimer's care director-B wheeled R153 to day room. At 10:09 a.m. nursing assistant (NA)-E approached R153 in day room during activities and asked R153 if would like to go to room and be changed. (NA-E asked quietly) R153 said,	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, A LIVINGCENTER - ST LOUIS PARK PL 3201 VIRGINIA AVEN SAINT LOUIS PARK, PL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 33 2 900 of nursing services must coordinate the development of a nursing care plan which provides that: 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to 2 of 3 residents (R153, R181) reviewed for potential skin breakdown. Findings include: R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. for repositioning. • At 7:00 a.m. R153 sitting in dining room. A mechanical lift sling under R153. • At 9:05 a.m. R153 sitting in dining room. A mechanical hele, position unchanged since 7:00 a.m. • At 9:30 a.m. Alzheimer's care director-B wheeled R153 to day room. • At 9:49 a.m. R153 sitting in activity room. • At 9:49 a.m. R153 sitting in activity room. • At 9:49 a.m. nursing assistant (NA)-E approached R153 if would like to go to room and be changed. (NA-E asked quietly) R153 said,	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 Image: Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIPED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Provider's Active PROVIDER'S PLAN OF OC (EACH ODERICTIVE ACTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Provider's Active PROVIDER'S PLAN OF OC (EACH ODERICTIVE ACTIVE TAG Continued From page 33 2 900 of nursing services must coordinate the development of a nursing care plan which provides that: Image: Provider's Active Condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. corrected This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to 2 of 3 residents (R153, R181) reviewed for potential skin breakdown. corrected Findings include: R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. for reposition unchanged since 7:00 a.m. - A1 9:49 a.m. R153 stitting in dining room. A mechanical lift sling under R153. - A1 9:05 a.m. Alzheimer's care director-B wheeled R153 to day room. - A1 9:49 a.m. Alzheimer's care director-B wheeled R153 in twould like to go to room and be changed. (NA-E asked quietly) R153 said,	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINA AVENUE SOUTH SAINT LOUIS PARK PL 3201 VIRGINA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 Image: Continued From page 33 PROVIDERS PLAN OF CORRECTIVE ACTOR SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 33 2 900 of nursing services must coordinate the development of a nursing care plan which provides that: 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and corrected B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new words for potential skin breakdown. corrected Findings include: R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. for repositioning. - At 7:00 a.m. Alzheimer's care director-B wheeled R153 it mig in dining room. - At 9:05 a.m. Alzheimer's care director-B wheeled R153 it mould like to go to room and be changed (NAE asked quietty) R153 said,

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		— 01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S		RGINIA AVENU OUIS PARK, M			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 34	2 900			
	asking permission. - At 10:25 a.m. R1. area to the coccyx immediately above The coccyx had ar (cm.) x 1.5 cm nor Registered nurse (verified the coccyx The Pressure Ulce (CAA) dated 6/26/- pressure r/t [relate [stroke] with weakr requires staff assis see MDS [Minimur daily living]/contine at risk for pressure decline."	53's bottom was red from peri The area from peri area to the rectum was blanchable. approximately 4 centimeter blanchable red area. (RN)-D was present and was red and not blanchable. er Care Area Assessment 15, indicated "CAA triggered fo d to] Hx [history of] of CVA ness, res. is incontinent, stance with bed mobility/cares, m Data Set] ADL[activities of ence coding. Res. [resident] is a, infection, pain and overall	r			
	9/22/15,indicated F and left heels and	ve Skin Assessment dated R153 had a current ulcer right a history of pressure ulcer on on indicated reposition every				
	resident was cogni assistance with AD incontinent of bow	IDS dated 11/17/15, indicated itively intact, required DLs, and was always el and bladder. R153's uarterly MDS included stroke, od disorder.				
	ulcer present to rig tissue injury. Ulcer Interventions incluer resident was in been that are stationary	sed 1/12/16, indicated pressure ht heel - suspected deep ation to left lateral malleolus. ded heel boots to be worn whil d and had specialized boots in wheelchair, provided by s while in bed, and offload				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
		00943	B. WING	B. WING		14/2016	
	PROVIDER OR SUPPLIER	SI OLUIS PARK PL 3201 VIR	ADDRESS, CITY, STATE, ZIP CODE RGINIA AVENUE SOUTH .OUIS PARK, MN 55426				
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 900	for R153 instructed repositioning scheo of two with off load	ng Assistant Assignment Shee I staff that R153 turning and Jule was R153 required assist ing and transfers using a large cal lift. R153 was to have boots					
	until 8:55 a.m. for r - At 7:00 a.m. R18 Mechanical lift sling - At 7:45 a.m. NA-E R181 - At 7:56 a.m. brea and NA-B started to - At 8:10 a.m. spee at the dining room - At 8:46 a.m. NA-E room and took to re transferred R181 fr mechanical lift. The red from front to ap cm above the rectu	1 was sitting in dining room. g under R181. 3 sat down and talked with kfast was delivered to R181 o feed R181. ch therapy working with R181					
	indicated "CAA trig incontinence. Res UTI [urinary tract in to ensure staff awa	ce CAA dated 12/24/15, gered dr/t [sic] urine is at risk for skin break down, ifection]. Proceed to care plan ire and provide care PRN [as ID [medical doctor] NP [nurse					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00943	B. WING		01/	14/2016
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - S		GINIA AVENU DUIS PARK, M			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 900	During interview or said R153 was the started at about 6:4 7:00 a.m. [R153] w been asked or refu our first resident to laid down and char a.m. Then 1:00 p.m. changing and repo refuse toileting." - At 9:56 a.m. LPN repositioned every acknowledged R18 two hours. - At 10:11 a.m. NA4 around 6:30 a.m." - At 10:13 a.m. RN repositioned every there would be skin potential deep vein contractures." RN- repositioned every there would be skin potential deep vein contractures." - At 2:47 p.m. NA-E double. NA-B state staffed." When ask be repositioned NA4 do the every two he and changing beca then it takes you 15 to do the next one. - At 2:55 p.m. NA-E	n 1/13/16, at 9:49 a.m. NA-B third resident to get up. "We 45 a.m. and were done about vas taken for activities, has not sed this morning. [R181] was get up at 6:10 a.m. [R181] is nged after breakfast then at 11 n. [R181] is every two hours for sitioning. [R181] does not -B said (R153) was to be				
		en Clinical Services Skin instructed staff to "reposition				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED	
		00943	B. WING		01/	01/14/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			01/14/2010	
	LIVINGCENTER - S	T LOUIS PARK PL 3201 VIF	RGINIA AVENU	E SOUTH			
		SAINTL	OUIS PARK, M				
(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 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE	
2 900	Continued From pa	age 37	2 900				
	taking into conside tolerance and choic condition of skin. I individualized plan	r as needed and tolerated, ration patient/resident ce, tissue tolerance, current ndicate frequency in the of care" and "Care plan is to valuated and revised based or sident."	1				
	director of nursing inservice staff rega plan to ensure app ulcers, and then au	THOD OF CORRECTION: The (DON) or designee could arding implementation of a care ropriate treatment of pressure udit to ensure compliance.	•				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			2/23/16	
	have a continuous management to red unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trad	ence. A nursing home must program of bowel and bladder duce incontinence and the of catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized t's clinical condition indicates to was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.					
	This MN Requirem	ent is not met as evidenced					

ATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
AME OF PROVID	ER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	IGCENTER - S		RGINIA AVEN .OUIS PARK,			
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910 Cont	inued From pa	age 38	2 910			
revie assis resic addi assis resic	w, the facility f stance with act lent (R153) wh ion, the facility stance with inc	ion, interview, and document ailed to provide timely ivities of daily living for 1 of 3 to was incontinent of stool. In failed to provide timely ontinence care for 3 of 4 53, R181) reviewed for urinary	/	corrected		
Find	ngs include:					
until least appr and be c "No." after NA-I with urine was was! R153 incol with satu incol area	3 was observe 10:35 a.m. and three hours. A oached R153 asked R153 if hanged. (NA-E ' At 10:19 a.m. asking permis D transferred F mechanical lift present when present and ver- hed hands, put 3's pants. NA-E thinence brief. urine and RN- rated. NA-D win thinence wipe. htinence wipe.	d on 1/13/16, from 7:00 a.m. d R153 was not toileted for at At 10:09 a.m. NA-E in day room during activities would like to go to room and asked quietly) R153 said, . NA-B brought R153 to room sion. At 10:25 a.m. NA-B and R153 from wheel chair to bed to R153 was lying in bed. RN-D erified the urine odor. NA-B to n gloves, and removed B removed R153's The product was saturated D verified the brief was iped R153's bottom with an Brown stool observed on NA-D washed R153's peri front, then applied new				
11/1 for b diag	7/15, indicated owel and blade nosis of demei	nt dated 6/15/15 and reviewed resident was not appropriate der retraining program due to ntia, psychosis and unspecifie sease. Staff was to toilet R153	d			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00943	B. WING	B. WING		14/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - ST	ELOUIS PARK PI	RGINIA AVENU OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 39	2 910			
	every 2 hours and	as needed.				
	(CAA) dated 6/26/1 for incontinence r/t incontinent of bowe ADL/continence co Skin CAA triggered	inence Care area assessment [5, indicated, "CAA triggered [related to] res. [resident] is el and bladder, see MDs (sic) oding. Res. is at risk for UTI, for incontinence r/t res. is at reakdown, unmet hygiene				
	Bladder, Incontiner plan dated 6/29/15	limination of Bowel and nce of bowel and bladder care , instructed staff to check and very two hours and as needed.				
	physical functioning impairment, and m goals were that R1 odor free. Care pla required extensive personal hygiene, b	/18/15, indicated R153 had a g deficit related to self-care obility impairment. Care plan 53 would be clean, dry, and in instructed staff that R153 assist of one for dressing, bathing, and toileting. It also d a history of refusing some pending on mood.				
	for R153 instructed incontinent of bowe	ng assistant assignment sheet I staff that R153 was el and bladder and was to be ge every two hours.				
	said, "[R153] was of started at about 6:4 7:00 a.m. [R153] w not been asked or - At 9:56 a.m. licen said R153 was to b	n 1/13/16, at 9:49 a.m. NA-B bur third resident to get up. We 45 a.m. and were done about vas taken for activities and had refused that morning. sed practical nurse (LPN)-B be repositioned every two hours. ange every two hours. R153				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943	B. WING	B. WING		14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - ST	I OHIS PARK PI	GINIA AVENU DUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 40	2 910			
	two hours. LPN-B s someone take care - At 10:11 a.m. NA- around 6:30 a.m. - At 10:13 a.m. regi R153 was to be rep offered to be chang - At 2:47 p.m. nursi was working a dout are short staffed." M residents to the bat NA-B said, "You ca hours turning and re because you need you 15 to 30 minute one. How can you f - At 2:55 p.m. NA-E time to do the repos two hours. We are best." NA-D said, "I to back, but I wiped front. I am not sure - At 9:22 a.m. the d (DNS) said, "I expe regarding incontine check and change their care plans." R incontinent cares are A bowel assessment Facility procedure I Management/Blado effective date 1/19/ bladder management urinary incontinence as normal bladder of The section "Choose	E stated we got R153 up stered nurse (RN)-D stated positioned every two hours and led every two hours. Ing assistant (NA)-B stated ole. NA-B stated, "right now we When asked about assisting hroom and to be repositioned nnot always do the every two epositioning and changing two people and then it takes as and you need to do the next ix it?" D said, "I don't always have sitioning and toileting every so busy right now. We do our know I am to wipe from front I both of them from back to why. They could get sick." irector of nursing services ct the staff to follow our policy nce care I expect them to residents in accordance to 153 was not provided ccording to the plan of care.				

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00943	B. WING	B. WING		14/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - ST	ELOHIS PARK PI	GINIA AVENU DUIS PARK, M			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLE DATE
2 910	Continued From pa	age 41	2 910			
	unable to participat resident should be program. Absorber collection devices w policy in conjunctio Changing programs incontinence." The lacked instructions	essful at toilet training or is e in retraining than the placed on incontinence care it products and external will be used as per center n with incontinence care. s are also driven by patterns or facility provided procedure regarding the development of tion to nursing assistants on	;			
		p.m. during room observation nted to have a musty urine				
	visit to the room a s	' a.m. during a subsequent strong smell of air fresher was vhich masked the urine smell.				
	room strong urine s not in the room at t asked what time re get ready for the da stated 6:45 a.m. At R13 smiled and wa heard to be unders R13 remained at th breakfast. At 9:12 a on wheelchair outs licensed practical n R13 down the hallw lounge. At 9:25 a.m herself down the ha lost and confused.	a.m. upon entering R13's smell was noted but R13 was he time. At 7:17 a.m. when sident had been assisted to ay nursing assistant (NA)-B 7:18 a.m. when approached is talking to surveyor but was tood. At 7:51 a.m. to 9:12 a.m. he dining room table for a.m. R13 was observed seated ide her room. At 9:20 a.m. hurse (LPN)-B was wheeled vay to the television (TV) h. R13 was observed wheeling allway wandering, appeared At 9:29 a.m. NA-B was				
nesota D	observed approach	o room. At 9:33 a.m. NA-B and				

DP PLAN OF CORRECTION IDEMTIFICATION NUMBER: A. BUILDING: COMPLETED 00943 B. WING 01/14/2010 WE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 30/11/14/2010 SUMMARY STATEMENT OF DEFICIENCES IDEMETRY STATEMENT OF DEFICIENCES IDEMETRY MAC DEFICIENCY WARTS FREE PROVIDED BY FULL IDEMETRY STATEMENT OF DEFICIENCES IDEMETRY TAG CONTRACTOR STATEMENT OF DEFICIENCES IDEMETRY PROVIDERS PLAN OF COMPRIST CONTRACTORY TAG CONTRACTOR STATEMENT OF DEFICIENCES IDEMETRY PROVIDERS PLAN OF COMPRIST CONTRACTORY COMPLETED TAG CONTRACTORY OF LSC DEATENTING NETWORK STATEMENT OF DEFICIENCES IDEMETRY PROVIDERS PLAN OF COMPRIST CONTRACTORY COMPLETED TAG CONTRACTORY OF LSC DEATENTING NETWORK STATEMENT OF DEFICIENCES IDEMETRY PROVIDERS PLAN OF CONTRACTORY COMPLETED 2910 Continued From page 42 2 910 IDEMETRY IDEMETRY IDEMETRY COMPLETED 2910 Continued From page 42 2 910 IDEMETRY IDEMETRY IDEMETRY COMPLETED 2910 Continued From page 42 2 910 IDEMETRY IDEMETRY IDEMETRY IDEMETRY		ta Department of He		<u> </u>			
Image: Note of PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, ZP CODE SUDEN LIVINGCENTER - ST LOUIS PARK IL 3201 VIRGINIA AVENUE SOUTH SANT LOUIS PARK, NN 55426 VIRING CENTER - ST LOUIS PARK IL 3201 VIRGINIA AVENUE SOUTH SANT LOUIS PARK, NN 55426 VIRING CENTER - ST LOUIS PARK IL 3201 VIRGINIA AVENUE SOUTH SANT LOUIS PARK, NN 55426 VIRING CENTER - ST LOUIS PARK IL 0			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
Image: Component of the intervence				A. DUILDING.			
DUDEN LIVINGCENTER - ST LOUIS PARK IN. 3201 VIRGINIA AVENUE SOUTH SANT LOUIS PARK, NN 55426 XM_1 D. REFK REACH DERIDENCY MUST BE PERCEDED BY FULL REFK ID PERCENT REACH DERIDENCY MUST BE PERCEDED BY FULL REACH DERIDENCY MUST BE PERCEDED BY FULL RESIDENT FULL AND			00943	B. WING		01/	14/2016
Dubbe DUBBE Display State SAINT LOUIS PARK, MN 55426 VALUE SUMMARY STATEMENT OF DEPENDENCES POVIDERS PLAN OF CORRECTION (EACH DEPINDENCY MIGT BE PRECEDED BY FILL) POVIDERS PLAN OF CORRECTION (EACH DEPINDENCY ON ISSO DENTIFYING WROMATION) PARK, MN 55426 2910 Continued From page 42 2 910 PRECISION (EACH DEPINDENCY ON ISSO DENTIFYING WROMATION) PARK, MN 55426 2910 NA-C approached resident. Then NA-B handed a communication card to resident to read and resident nodue her head then both staff wheeled resident nodue and to resident but resident refused. NA's then wheeled R13 out of the bathroom into the room and NA-B indicated was going to re-attempt to toilet R13 in 15 minutes. The model and the resident hut resident refused. NA's then wheeled R13 out of the bathroom into the room and NA's never offered to check and change R13 which was two hours and 45 minutes. NA-B 3000 a.m. R13 was observed self transfer to a regular shift transfer back to the wheelchair then was observed wheeling down the hallway towards the nursing station. NA 19:37 a.m. NR 13 gain self transfer back to the wheelchair then was observed wheeling to grab on male staff NA-B. NA 10:04 a.m. LPN-B finally suggested to lay resident down in be Alt-B assident station was all attempting to grab on male staff NA-B. NA 10:05 a.m. LPN-B and NA-B assited 'you needed it: "R13's pants and incontinent pad wree observed socident toidet R10 13 a.m. LPN-B checked the wheelchair cushion stated 'You needed it: "R13's pants and incontinent pad wree observed sociat stood up LPN-B stated 'You needed it: "R13's pants and incontinent pad wree observed sociak w	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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			15 a.m. INA-B acknowledged				
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	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00943		00943	B. WING		01/14/2016	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		14/2010
	I LIVINGCENTER - S	ELOUIS PARK PI	GINIA AVENUI			
		SAINT L	OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pa	age 43	2 910			
	over one hour and resident had last be NA-B stated "We a the residents in the transfers because and some are com the room for half he another resident in go now. Someone are under staffed a aides with heavy ca even take a 15 min will be lunch here of -At 10:26 a.m. LPN follow the plan of c toilet the resident ti would have expect was running late to	een toileted timely and was 15 minutes from when een checked and changed. The under staffed and some of a unit need two staff with they use the transfer machine bative and if two aides go into our they is no way I can tell the middle of cares I have to can point a finger at me but we and for 27 residents for two ares it's impossible. I have not nute break and in 20 minutes coming and am shaking." I stated NA's were supposed to are and were supposed to mely. LPN-B further stated she ed NA-B to report to her he toilet and resident had ould have attempted to ent as she did.)			
	disorder, unspecifie infarction without re osteoarthritis, unsp behavioral disturba	acluded schizoaffective ed hearing loss, cerebral esidual deficits, unspecified becified dementia with unce and conduct disorder admission record dated				
	Care Area Assessmidentified resident v bladder, was at risk tract infections and plan dated 11/13/14 functional incontine Care plan directed	ntinence Indwelling Catheter nent (CAA) dated 10/14/15, was incontinent of bowel and k for urine body odor, urinary l skin breakdown. R13's care 4, identified resident had a ence of bladder and bowel. staff to provide assistance of riefs/pads for incontinence				

STATEMEN	ta Department of Hereit of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00943	B. WING		01/14/2016	
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	LIVINGCENTER - S		GINIA AVENU DUIS PARK, N			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 44	2 910			
	and as needed.					
	R13's comprehensive assessment dated 1/4/16, indicated R13 was incontinent of bowel and bladder and directed staff to check and assist every two hours and as needed as resident allowed.					
	until 10:35 a.m. an least three hours. A approached R153 and asked R153 if be changed. (NA-E "No." At 10:19 a.m after asking permis NA-D transferred F with mechanical lif urine present when registered nurse (F the urine odor. NA- gloves, and remov removed R153's in was saturated with brief was saturated with an incontinence on incontinence with	ed on 1/13/16, from 7:00 a.m. d R153 was not toileted for at At 10:09 a.m. NA-E in day room during activities would like to go to room and E asked quietly) R153 said, . NA-B brought R153 to room ssion. At 10:25 a.m. NA-B and R153 from wheel chair to bed t. There was a strong odor of n R153 was lying in bed. RN)-D was present and verified -B washed hands, put on ed R153's pants. NA-B iscontinence brief. The product ourine and RN-D verified the d. NA-D wiped R153's bottom ce wipe. Brown stool observed pe. NA-D washed R153's peri front, then applied new				
	11/17/15, indicated for bowel and blad diagnosis of deme	ent dated 6/15/15, and reviewed I resident was not appropriate der retraining program due to ntia, psychosis and unspecified sease. Staff was to toilet R153 nd as needed.				
nesota De		inence CAA dated 6/26/15, ggered for incontinence r/t				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOLDEN	LIVINGCENTER - S		GINIA AVENU OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 45	2 910			
	and bladder, see M ADL [activities of d Res. is at risk for L CAA triggered for in for UTI, skin break The Alteration in El Bladder, Incontiner plan dated 6/29/15 change resident ev R153's quarterly M resident was cogni assistance with AD incontinent of bowe	sident] is incontinent of bowel IDs [sic- Minimum Data Set] aily living]/continence coding. JTI [urinary tract infection], Skir ncontinence r/t res. is at risk down, unmet hygiene needs." limination of Bowel and nce of bowel and bladder care , instructed staff to check and very two hours and as needed. DS dated 11/17/15, indicated tively intact, required PLs, and was always el and bladder. R153's Jarterly MDS included Stroke, pd disorder.				
	physical functioning impairment, and m goals were that R1 odor free. Care pla required extensive personal hygiene, I	/18/15, indicated R153 had a g deficit related to self-care obility impairment. Care plan 53 would be clean, dry, and n instructed staff that R153 assist of one for dressing, bathing, and toileting. It also d a history of refusing some pending on mood.				
	for R153 instructed incontinent of bowe	ng Assistant Assignment Shee I staff that R153 was el and bladder and was to be ge every two hours.	t			
	until 8:55 a.m. at 7 dining room. During care on 1/13/16, fro	d on 1/13/16, from 7:00 a.m. :00 a.m. R181 was sitting in g observation of incontinence om 8:46 a.m. until 8:55 a.m. ansferred R181 from				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/14/2016	
-	PROVIDER OR SUPPLIER	3201 VI	DDRESS, CITY, ST			
OLDEN	I LIVINGCENTER - S		OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pa	age 46	2 910			
	applied gloves and opened incontinent observed to be red four centimeter cm NA-D touched skin incontinent brief wa	using a mechanical lift. NA-D removed R181's pants and ce brief. The peri area from front to approximately above the rectum. When , area blanched. The as completely saturated with d brief was saturated with				
	indicated R181 had incontinence and w	sment dated 12/22/15, d functional urinary vas not appropriate for toileting am because of dementia and	,			
	resident was mode required assistance incontinent of blade	MDS dated 12/22/15, indicated trately impaired cognitively, e with ADLs, and was always der and frequently incontinent ignoses included traumatic mentia.	ł			
	indicated "CAA trig incontinence. Res UTI. Proceed to ca and provide care P	ce CAA dated 12/24/15, gered dr/t [sic] urine is at risk for skin break down, re plan to ensure staff aware RN [as needed]. Update MD P [nurse practioner] PRN."				
	was functionally inc	d 1/12/16, indicated resident continent of bowel and bladder o check and change R181 eeded.				
	for R181 instructed	ng Assistant Assignment Sheet I staff that R181 was s to be checked and change Id as needed.				

TATEMENT OF DEFICI ND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00943	B. WING	B. WING		14/2016
AME OF PROVIDER O	R SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
OLDEN LIVINGCI	ENTER - ST		RGINIA AVENU .OUIS PARK, N			
(X4) ID S	IMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX (EACH	I DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COMPLET
2 910 Continue	d From pa	ige 47	2 910			
said, "[R started a 7:00 a.m not been was our f [R181] is then at 1 two hours does not - At 9:56 reposition change e be chang been toile LPN-B w away. R1 two hours - At 10:13 reposition changed - At 10:13 reposition changed - At 2:47 NA-B sta When as bathroom cannot a reposition two peop and you n it?"	153] was of t about 6:4 . [R153] w asked or r irst reside laid down 1 a.m. The s for chang refuse toil a.m. LPN- ned every every two h red. LPN-E eted in ove ould have 81 was to s. a.m. NA- 30 a.m. 3 a.m. RN- ned every every two p.m. NA-E ted, "Righ" ked about n and to be ways do the need to do p.m. NA-E reposition e are so b	B said R153 was to be two hours and check and hours. R153 could also ask to a cknowledged R153 had not er two hours. LPN-B stated someone take care of it right be checked and change ever E stated we got R153 up -D stated R153 was to be two hours and offered to be hours. B stated was working a double t now we are short staffed." assisting residents to the e repositioned NA-B said, "You he every two hours turning and hanging because you need n it takes you 15 to 30 minute the next one. How can you fit D said "I don't always have tim ing and toileting every two busy right now. We do our	t y e. d s x e			
best." NA to back, I	-D said, "I out I wiped	know I am to wipe from front both of them from back to				
		why. They could get sick." lirector of nursing services				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943	B. WING	B. WING		14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S		RGINIA AVENU OUIS PARK, M			
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 48	2 910			
	check and change	ence care I expect them to residents in accordance to 153 and R181 was not nt cares.				
	effective date 1/19 bladder managem urinary incontinent as normal bladder The section "Choo Resident After Eva resident is unsucce unable to participa resident should be program. Absorber collection devices policy in conjunctio	Incontinence der Function Guideline /15, Indicated the purpose of a ent program is to:" Manage e, restore or maintain as much function as possible". sing A Program That Fits The luation: "Instructs staff If essful at toilet training or is te in retraining than the placed on incontinence care nt products and external will be used as per center on with incontinence care. is are also driven by patterns of	1			
	integrity Guideline every two hours, o taking into conside tolerance and choi condition of skin. I individualized plan	en Clinical Services Skin instructed staff to "reposition r as needed and tolerated, tration patient/resident ce, tissue tolerance, current indicate frequency in the of care" and "Care plan is to valuated and revised based or esident."	1			
	facility could review review their policie to include individua schedules/plan/pro develop assessme on how to assess,	THOD OF CORRECTION: The v the state requirements, s/procedures and revise them alized toileting ogram, the facility could then ents and tools and educate stat implement, and maintain an ting plan for all residents. The				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:) DATE SURVEY COMPLETED
		00943	B. WING		01/14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - ST	LOUIS PARK PI	RGINIA AVEN OUIS PARK,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 910	Continued From pa	ge 49	2 910		
		evelop and implement an part of the quality assure n compliance.			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015		2/23/16
	procedures and co	conditions. Sanitary nditions must be maintained ir e dietary department at all	1		
	by: Based on observat review, the facility f procedures were for possibility of food b kitchen and in 6 of potential to 171 of	ent is not met as evidenced ion, interview, and document ailed to ensure food sanitation illowed to minimize the orne illness in the main 7 kitchenettes. This had the 175 who were served food 6 of 7 kitchenettes and the		corrected	
	Findings include:				
	11:48 a.m. to 12:52	and facility tour on 1/11/16, at p.m. with the director of lowing was observed:			
	oven was observed in place but white h heavy buildup of wh bottom arm, backs	nixer stationed next to the I to have a clean mixing bowl ardened food splatter and hite food debris around the ide and on and around the ixer. Food would come in			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00943	B. WING	B. WING		01/14/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - S	ELOUIS PARK PI	GINIA AVENU OUIS PARK, M				
(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 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21015	Continued From pa	age 50	21015				
	needed to be clear	bris. The DD verified the mixen ned, stating "It was used king one of the staff he then clean it.					
	white flaky porous dishwasher and on Inside the dishwas observed a chute/v build up which flake stated the dishwas	vas observed to have heavy lime build up all around the the inside of the clean side. her on the clean side was vent that had heavy porous lime ed off with touch. DD verified her was de-limed once a week n use the staff cleaned it.					
	between the steam the gas stove and of food prep station a across from the ga approximately 22 in to be dirty, covered	rute trash cans stationed her and food warmer; between oven and another between the nd the one compartment sink is stove and oven which was inches were all three observed with heavy amounts of food is in the entire outside of the					
	stored and the insid a black substance pans. DD verified s cleaned. On a follo frying pans were as	ans were observed on the de of both had heavy buildup o on the cooking surface of the stated they were going to be w up tour on 1/12/15, the two gain observed on the stove still uildup on the inside cooking tire side.					
	white flaky porous dishwasher and on Inside the dishwas observed a chute/v build up which flake	vas observed to have heavy lime build up all around the the inside of the clean side. her on the clean side was vent that had heavy porous lime ed off with touch. DD verified her was de-limed once a week					

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ST LOUIS PARK PL 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 (X) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LISC IDENTIFYING INFORMATION ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODRICTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 21015 Continued From page 51 and then after each use the staff cleaned it. 21015 21015 ACU kitchenette, the oven below the microwave was observed with heavy black charcoal like stuff inside the oven and on the racks. When asked who was responsible for cleaning the oven, DD stated as far as he knew his detary staff did not use the oven and thought activities department used it. When asked who cleaned the oven DD stated he was not sure and "if it was my department it would be the first time to know." In addition, DD verified the microwave had brown dried on food debris on the inside. AACU kitchenette, the resident ice machine was observed to be slowy dripping near the spoul and noted to have stagnart water in the catch basin which was not draining the DD stated he was not ware it was dripping and there was someone who cleaned the ice machine three times weekly and was supposed to let him know to put a work order in the facility building engines. DD further stated nursing was also able to put a work order if they were aware the ice machine was dripping. 1 North kitchenette, the resident microwave was observed with dried brown yellow food splatters DD verified stated here was a staff who came between meals to restock the refrigerators and would then clean. DD verified it had been signed off as cleaned but was not.<	STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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		observed with dried DD verified stated between meals to would then clean. I	d brown yellow food splatters there was a staff who came restock the refrigerators and DD verified it had been signed				
2 North kitchenette, both the resident refrigerator and freezer were observed to have dried on juice spills in the inside and the freezer had cardboard and food debris. DD verified stated the cleaning sheet had been signed off also but was not clean.		and freezer were of spills in the inside a and food debris. D	bserved to have dried on juice and the freezer had cardboard D verified stated the cleaning				
2 South kitchenette, the resident microwave was observed with brown dried on food spatters in the nnesota Department of Health	ana sati D	observed with brow					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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21015	Continued From pa	age 52	21015			
	observed with heav old bread crumbs i grates. DD verified supposed to be cle heavy bread crumb 2 East fridge kitche was observed with door seal in the ins underneath the cris dried buildup was r toaster was noted	he resident toaster was by buildup deposits of greasy in the inside of the toaster stated toasters were aned daily. Acknowledged the bs buildup. enette, the resident refrigerator dried juice spills around the ide and at the bottom spy drawers a heavy brown noted. In addition, the resident with heavy deposits of bread le grates DD verified stated				
	kitchen tour, the stu observed to have to build up coating rea Upon the cook oper up the aluminum for steel containers we dried on stains. Wh	p.m. during a follow up eamer glass door was been cleaned however a white mained in the inside and door. ening the steamer for meal set bil used to cover the stainless ere all observed to have white hen asked what the stains were stated was from the steam e steamer.				
	the frying pans wer down on the stove. them over and both heavy substance o entire sides. DD sta cleaned. Immediate aides clean them. observed cleaning cleaner then was s able to get the blace heard ask the dieta	B a.m. during a follow up tour re observed turned upside DD was requested to turn n were observed still with n the cooking surface and the ated they still needed to be ely DD had one of the dietary At 10:16 a.m. dietary aide was the frying pans with steel een use a scrape but was not sk buildup off. DD then was ary aide to throw the frying pan had ordered new ones to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		DDRESS, CITY, ST CINIA AVENUI OUIS PARK, M	E SOUTH	<u>.</u>	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	and policies and the requested DD state company represent buildup would also opened the steame buildup and verified was a thin film of d Sanitation Overvier indicated "It is the department to prace techniques for clear outbreak of foodbo Service employees Food code 4-601.1 surfaces, nonfood- utensils.* (1) Equipment, foo utensils must be cl (2) The food-contate equipment and part encrusted grease of accumulations. (3) Non-food-contate be kept free of an arresidue, and other SUGGESTED MET The director of diet cleaning schedule develop a system to schedule. The dire also provide educate prevention of food sanitary practices.	D acknowledged the findings the manual for the steamer were ed he had spoken with the stative who had indicated the come back. DD and surveyor er and DD verified the lime d on the bottom of the steamer lust that was collecting. w policy reviewed 2/12/2015, policy of the Dining Services ctice proper sanitation an equipment to prevent the prime illness, and to train Dining is to use these techniques 11Equipment, food-contact contact surfaces, and dean to sight and touch. act surfaces of cooking ins must be kept free of deposits and other soil act surfaces of equipment must accumulation of dust, dirt, food				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	3201 VIR	DDRESS, CITY, GINIA AVEN DUIS PARK,		
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21375	Continued From pa	ige 54	21375		
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375		2/23/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on observati review, the facility f work surfaces were of 5 units in which 5 addition, the facility handwashing was p	ent is not met as evidenced ion, interview, and document ailed to ensure equipment and e kept clean and sanitary for 1 50 residents resided. In to ensure proper performed for 2 of 4 residents were observed for cares.		corrected	
	Findings include:				
	administration was set up registered nu hygiene, poured a d water for R93 and s nursing station desi medications, she th water and added m the medication cup top of the nursing s and black debris wa	a.m. a medication set up and observed for R93, during the urse (RN)-K performed hand class of room temperature set it on top of the 2 East k while she prepared 7 hen picked up the glass of ore water to it, then picked up and entered R93's room. The tation desk had tape debris as stuck to it. RN-K moved ations and the cup of water and hygiene.			
	(LPN)-F verified the debris in the crushi	0 a.m. licensed practical nurse Silent Knight Pill crusher had ng area, and along the sides The debris was white, brown			

Minnesc	ota Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	:		
		00943	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
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			OUIS PARK, I	PROVIDER'S PLAN OF C		()(5)
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21375	Continued From pa	age 55	21375			
	and black and coul fingernail. The pill of three medication ca medication prepara top of the nursing s and black debris w carts were placed i desks and medicat dispensed form the The Cleaning and I Items and Equipme directed: "Resident-care equitems and durable cleaned and disinfer recommendations Bloodborne Pathog 1. c. Non-Critical if where they are use 7. Intermediate and non-critical items in a. ethyl or isop b. Sodium hype c. Phenolic ger d. lodophor gel e. Quaternary a detergents."	d be scraped off with a crushers were on top of the arts, in an area used for ation. LPN-F further verified the station desk had tape debris as stuck to it. The medication n front of the 2 East nursing ions were sometimes e desk area. Disinfection of Resident-Care ent policy dated 8/2014, upment, including reusable medical equipment will be ected according to current CDC for disinfection and the OSHA gens Standard. tems can be decontaminated ed. d low-level disinfectants for nclude: ropyl alcohol; ochlorite; micidal detergents and rmicidal detergents; ammonium germicidal	,			
	bladder. During observation 1/13/16, from 10:2!	lways incontinent of bowel and of incontinence cares on 5 a.m. until 10:35 a.m. and RN)-D present for entire				
linnesota D	epartment of Health					
TATE FOR			6899	76C411	lf continuati	on sheet 56 of

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOLDEN LIVINGCENTER - ST LOUS PARK PL 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 Image: Contract Contend Contrant Contrant Contract Contract Contract Contract Contene			00943	B. WING		01/14/201	
SOLDEN LIVINGCENTER - ST LOUIS PARK PL SAINT LOUIS PARK, MN 55426 (X4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX (EACH DEFICIENCY) PREFX (EACH DEFICIENCY) PREFX TAG 21375 Continued From page 56 observation. Nursing assistant (NA)-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. A strong odor of urine noted when R153 lying in bed and RN-D verified urine odor. NA-B washed hands, put on gloves, and removed R153's pants. NA-B removed R153's incontinence brief. The product was saturated. NA-B wiped abdominal folds and top of perineum. NA-B removed gloves and put on new gloves after using sanitizer.NA-D assisted R153 to roll on left side. R153's bottom was red from peri area to the coccyx. The area from peri area to immediately above the rectum was blanchable. The coccyx had an approximately 4 centimeter (cm.) x 1.5 cm non blanchable red area. RN-D verified coccyx was red and not blanchable. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. Brown stool observed on incontinence wipe. Brown stool observed no incontinence wipe. Brown s	IAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
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R181's admission MDS dated 12/22/15, indicated resident was moderately impaired cognitively, required assistance with ADLs, and was always incontinent of bladder and frequently incontinent of stool. During observation of incontinence care on 1/13/16, at 8:46 a.m. from 8:46 a.m. until 8:55 a.m.		transferred R153 fr mechanical lift. A s R153 lying in bed a NA-B washed hand R153's pants. NA-F incontinence brief. with urine. RN-D ve NA-B wiped abdom NA-B removed glov after using sanitize on left side. R153's area to the coccyx. immediately above The coccyx had an (cm.) x 1.5 cm non verified coccyx was wiped R153's botto Brown stool observ. NA-D washed R15 front, then removed new gloves on with applied new incont boots on R153's fe removed gloves, st gloves on. NA-D cl brief and incontinen soiled utility room a hands. R181's admission I resident was mode required assistance incontinent of blade of stool. During observation 1/13/16, at 8:46 a.r	The product was saturated and RN-D verified urine odor. ds, put on gloves, and removed B removed R153's The product was saturated erified brief was saturated erified brief was saturated inial folds and top of perineum. Ves and put on new gloves r.NA-D assisted R153 to roll bottom was red from peri The area from peri area to the rectum was blanchable. The area from peri area to the rectum was blanchable. The area from peri area to the rectum was blanchable. The area from beak to the sect area area. RN-D s red and not blanchable. NA-D on with an incontinence wipe. Yed on incontinence wipe. 3's peri area from back to d the soiled gloves and put tout washing hands. NA-D inence brief. NA-D put blue et and pulled up covers, then traightened room and put new osed the plastic bag with soiled nce wipes and took them to the and then NA-D their washed MDS dated 12/22/15, indicated erately impaired cognitively, e with ADLs, and was always der and frequently incontinent				

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NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, GINIA AVEN	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S		DUIS PARK,			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	age 57	21375			
	room. NA-D and N wheelchair to bed u applied gloves and opened incontinent be red from front to cm above the rectu area blanched. The completely saturated brief was saturated incontinence wipe to back. NA-E and NA-D wiped R181's stool visible on inco NA-D removed the gloves without was NA-D put R181's p covered resident u	soiled gloves, put on new hing hands or using sanitizer. ants and blue boots on. NA-D p. NA-D applied a new pair of hing hands and washed	t			
	stated, "I know I a	n 1/13/16, at 2:55 p.m. NA-D am to wipe from front to back, them from back to front. I am could get sick. "				
	director of nursing least use hand san gloves as long as t soiled. If the gloves wash their hands w immediate re-educ and then with all st usage. The staff ar to back to prevent the staff to follow o	n 1/14/16, at 9:22 a.m. the services expected staff to at nitizer when staff remove he gloves are not visible s are visible soiled staff are to with soap and water. " We did eation with the staff involved aff on hand washing and glove re to wipe a resident from front urinary tract infections. I expect our policy regarding and hand washing. "				
		al Care procedure dated				
linnesota D TATE FORI	epartment of Health M		6899	76C411	If continuati	on sheet 58 of 8

Minneso	ta Department of He	ealth			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00943	B. WING		01/14/2016	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S			
		3201 VIE				
GOLDEN	I LIVINGCENTER - S	ELOHIS PARK PI	OUIS PARK, M			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		COMPLETE DATE
ma		,	ind	DEFICIENCY)		
21375	Continued From pa	age 58	21375			
	12/9/15, instructs s	taff:				
	"11. Female perine	eal care				
		piled with feces, place resident				
		perineum and rectal area.				
	appropriately.	and discard soiled linen				
	c. Change gloves					
	d. Turn resident of					
		separate her legs and flex				
		able to spread her legs and flex	(
		l area can be washed with the				
	resident on the side					
		d hand to stabilize and				
	front to back.	with other hand wash from				
		ble to use bed pan place				
		and pour clean warm water o	r			
		over the vulva and perineum.				
		ell, remove bedpan, and				
	position resident or					
		direction to wash hands or use				
	sanitizer after char	iging solied gloves.				
	Wound Care					
		e was observed on 1/14/16, at s sitting in wheelchair. The left				
		ered with gauze. The bottom				
		s purple. Licensed practical				
		hed hands and put on gloves.				
		dage scissors from their pocke	t			
		ed gauze dressing. LPN-B did				
		ors prior to use. There was				
		ainage or ointment observed				
		-B cleaned R153's left ankle				
		saline and gauze. LPN-B I gloves and put new gloves				
		inds. LPN-B wiped the area				
		bund with a barrier wipe, then				
		ing supply caddy with the				
nnesota D	epartment of Health		μ			1

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00943	B. WING		01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - S	T LOHIS PARK PI	GINIA AVENU DUIS PARK, M			
(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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 59	21375			
	square of alginate, and a roll of gauze (a natural wound d scissors that cut th LPN-B applied Sar debriding ointment covered with algina and wrapped with g sock on right foot a prep sponge. The without redness or soiled scissors bac	Is and removed an open foam 2 cm by 2 cm dressing . LPN-B cut the clean alginate ressing) with the same soiled e soiled gauze dressing. htyl (a sterile enzymatic) using a cotton tipped swab, ate, then applied foam dressing gauze. LPN-B removed R153's and wiped right heel with skin right heel observed to be intact open areas. LPN-B placed the ck into the pocket without ssors, removed the soiled d their hands.				
	stated, "Generally glove changes. I at needed to. I did no cutting off the old c alginate. I did reac	n 1/14/16, at 8:01 a.m. LPN-B I do not wash hands between m not sure, I did not think I t wipe my scissors off after dressing and before cutting the h into the dressing supply ves on after I had cleaned the				
	said staff should ha alcohol after being to change gloves b clean dressing sup changed and hand soap and water aft	n 1/14/16, at 9:22 a.m. the DNS ave wiped the scissors of with used. DNS said, "I expect staff before reaching into a bucket of pplies. Gloves should be s cleaned with sanitizer or er completing one wound bing another treatment or nove their gloves."	:			
	procedure revised to: " 7. Use an alcoho	ashing/Hand Hygiene August 2014, instructed staff I-based hand rub containing at] alcohol, or, alternatively, soap				
nnesota De	epartment of Health	j alconol, ol, allematively, 50ap	' II			

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	• • •	
		3201 VIB	GINIA AVEN			
GOLDEN	I LIVINGCENTER - ST	SAINT LOUIS PARK PL	DUIS PARK,	MN 55426		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 60	21375			
	the following situati a. Before and afte b. Before after an c. Before preparin d. Before preparin d. Before perform procedures; e. Before and afte (e.g., urinary cathel f. Before donning g. Before handling gauze pads, etc.; h. Before moving to a clean body site i. After contact w j. After contact w k. After handling to equipment, etc.; l. After contact w equipment) in the in resident: and m. After removing n. Before and afte settings; o. Before and afte settings; o. Before and afte meals; and q. After personal hygie "9. The use of glow washing /hand hygi along with routine h the best practice fo healthcare-associa SUGGESTED MET The director of nurs and revise the polic infection control co medications, perfor	er coming on duty; d direct contact with residents; ng or handling medications; ing any non-surgical invasive er handling an invasive device ters, IV access sites); g sterile gloves; g clean or soiled dressings, from a contaminated body site e during resident care; ith resident's intact skin; ith blood or bodily fluids; used dressings, contaminated ith objects (e.g., medical mmediate vicinity of the gloves. er entering isolation precaution er eating or handling food; er assisting a resident with use of the toilet or conducting ene." es does not replace hand iene. Integration of glove use hand hygiene is recognized as r preventing				
STATE FOR	-		6899	76C411	If continuati	on sheet 61 of 83

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/14/201	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - ST	ELOUIS PARK PI	GINIA AVENU OUIS PARK, M			
(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	TION SHOULD BE COMF	
21375	Continued From pa	age 61	21375			
	monitoring system staff are providing	education to staff members. A could be developed to ensure cares as directed and report uality assurance committee.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	,			
21630	MN Rule 4658.135 Medications; Destr	0 Subp. 2 A.B. Disposition of uction	21630		2/23/	
	remaining in the nu discharge of a resid prescribed, or any discontinued perma manner recomment or the consultant pl pharmacist must fu instructions and for kept on file in the n B. Unused por drugs remaining in death or discharge were prescribed or discontinued perma according to part 6 be returned to the p 6800.2700, subpar destruction listing t medication, prescri	tions of controlled substances ursing home after death or dent for whom they were controlled substance anently must be destroyed in a ided by the Board of Pharmacy harmacist. The board or the urnish the necessary rms, a copy of which must be ursing home for two years. tions of other prescription the nursing home after the of the resident for whom they	,			
	This MN Requirem by:	ent is not met as evidenced				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ST	FI OLIIS PARK PI	GINIA AVEN DUIS PARK,			
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21630	Continued From pa	age 62	21630			
	review, the facility f medications were of units reviewed for r the facility failed to were disposed of in	tial to affect 132 of 175		corrected		
	Findings include:					
	R26 was admitted to the facility on 12/25/14, with admission diagnoses of acute respiratory failure and major depression.					
	(antianxiety medica ordered 1/6/15, R2 2015, 16 doses in I March 2015, zero o in May 2015, zero o doses in July 2015 doses in Septembe 2015, zero doses ii in December 2015 However, the Loraz	ers indicate Lorazepam ation) Intensol solution was 6 received 1 dose in January February 2015, zero doses in doses in April 2015, zero doses doses in June 2015, zero , 2 doses in August 2015, zero er 2015, zero doses in October n November 2015, zero doses , and was discontinued 1/5/16. zepam Intensol solution cured medication refrigerator 13/16.				
	7/9/15, indicated ch depression. The ca indicated impaired impaired communic (MDS) dated 9/18/1 cognitively impaired	rea Assessment (CAA) dated nanging cognitive function and are plan dated 7/22/15, cognitive function and cation. The Minimum Data Set 15, indicated R26 was severely d, and was totally dependent bility, toilet use, and dressing.				
nnesota De ATE FORM	medication storage) p.m. during a review of proom in the 1 North nursing	6899			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
	I LIVINGCENTER - S	T LOUIS PARK PI	GINIA AVENU			
		SAINT L	OUIS PARK, M			
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21630	Continued From pa	age 63	21630			
	registered nurse (F that a key was brok box, in the refrigera and attempted to e that was not succe remove the padloc The lock box conta solution 2 milligram approximately 12 m bottom of the meni was emptied). The written on it (to indi medication book th There were 3 numbers	ere R26 resided), with RN)-H and RN-G it was noted ken off in the narcotic storage ator. Maintenance-A was called xtract the broken key, when ssful a bolt cutter was used to k with the key broken off in it. tined Lorazepam Intensol ns/milliliter labeled for R26, with nl remaining in the vial (at the scus, once the dropper top medication box had numbers icate what page in the narcotic bers written on the box, 84, 84 indicated 13 mls should ial.				
	morning narcotic c mediations stored and counted, but n actually gone to the locked box to coun lock box and not th counted. RN-G and to be determined w the padlock, even t signed the narcotic count had been co	I-G had participated in the ount which verified that all and locked had been reviewed either of the nurses had e refrigerator and opened the t the drug. RN-G verified the ne medication itself had been d RN-H verified it was unable when the key was broken off in though RN-G and RN-H had books as if a full and accurate mpleted. The Lorazepam een administered on 8/28/15 hs prior).				
	service (DNS) arrives she had just been in the padlock, and to her previously. If was supposed to be	9 p.m. the director of nursing ved on the floor. DNS verified informed of the key broken off I that no-one had reported that DNS verified the narcotic count ie a visual count and nedications on the unit, and it				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
AME OF F	PROVIDER OR SUPPLIER	4	DDRESS, CITY, S	TATE, ZIP CODE		
	LIVINGCENTER - S		RGINIA AVENU .OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21630	Continued From pa	age 64	21630			
	she did not believe been diverted (and	bleted accurately. DNS stated any Lorazepam Intensol had I that it was considered a drug was why it had been locked				
	another medication showed the 13 mls been administered after the medicatio and the new volum The Lorazepam In been destroyed at months ago). The was supposed to b not had time yet. T 12/5/15. The DNS pharmacy service	B p.m. DNS located page 5 in n cart and narcotic book, which s, an additional three doses hav , last on 8/28/15 (3 months n should have been destroyed the total was now 12.25 mls. tensol solution should have the end of May 2015, (7 DNS stated the medication be destroyed and she had just the destroy [request] was dated verified the consultant performed periodic medication and audits for the facility.	d 1) d			
	medication had firs 2/20/15 at a volum 5 different rooms in documentation of t to be fully provided indicating where th transferred were no narcotic medication of what page and w medication had be	was unable to be read, the st been administered on e of 22 ml. R26 had moved to n the facility, and the he medication use was unable at that time (the notes ne medication had been ot present). DNS verified the n books lacked documentation what medication cart the en moved to, the narcotic uplicate pages that were not	•			
	broken off in the pa	e determined when the key hac adlock, as the narcotic counts of the secured medications on				

Minnesc	ta Department of He	ealth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S	T LOHIS PARK PI	GINIA AVENU			
	1	SAINT LO	DUIS PARK, I	1		1
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21630	Continued From pa	age 65	21630			
	On 1/14/16, at 12:3 pharmacist (CP) st building in July, so been an audit of th unsure when the p audited. CP stated day expiration for t stated if it was a m until the manufactu been compounded sooner. CP stated to audit all the fridg According to the pa 2012, the Lorazepa 36-46 degrees Fah after the medicatio The Storage of Me directed: "Medications and b following manufact those of the supplit to support safe adr supply is accessibl pharmacy persona authorized to admi 1. Medications are and may include m rooms, medication containers. 2. Non-controlled m identified by the nut the potential for ab controlled substant solution]. 11. Mediations required	30 p.m. the consultant cated he had taken over the January 2016 would have e medication rooms. He was revious pharmacist last he was not aware of the 90 he Lorazepam Intensol, and ulti-dose vial it should be good urer 's expiration date. If it had the expiration would be much the plan of correction would be ges quarterly.				
Minnesster	are kept in a refrige	erator with a thermometer.				
Minnesota D STATE FOR	epartment of Health M		6899	76C411	If continuation	on sheet 66 of 83

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - S		RGINIA AVENU .OUIS PARK, I			
(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	TION SHOULD BE	(X5) COMPLET DATE
21630	Continued From pa	age 66	21630			
	deteriorated medic that are cracked, s closures are imme disposed of accord medication disposa 16. "Medication sto on a regular basis ("QA") check. Reco	ontaminated, discontinued or ations and those in containers oiled, or without secure diately removed from stock, ling to procedures for al. orage conditions are monitored as a random quality assurance ommendations are made for ken as problems are	ł			
	The pharmacist an in-service all staff r	THOD OF CORRECTION: d/or director of nursing could esponsible for medications the dications and follow disposal of ding to the facility				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one)			
21665	MN Rule 4658.140	0 Physical Environment	21665			2/23/16
	functional, comfort environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.				
	by: Based on observat review, the facility t were free of splinte (2N had 29 resider residents which co and visitors on the	ent is not met as evidenced ion, interview, and document failed to maintain handrails that ers on outside of rooms 207 hts) and 232 (2S had 30 uld have been affected), staff, units, a clutter free m 240B and 268B, and tangle		corrected		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	LIVINGCENTER - S		GINIA AVENU OUIS PARK, M			
(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) COMPLET DATE
21665	Continued From pa	age 67	21665			
	electrical cords in r potential to cause a	oom 383B and had the accidents.				
	Findings include:					
	During a tour of the facility on 1/14/16, at 10:00 a.m. through 11:00 a.m. with the district manager (DM), administrator, director of maintenance, and director of environmental services (housekeeping and laundry) the following areas were a safety concern:					
	splintered and had - Rooms 240 B and personal items, clu - Room 383B had a cords near an outle	e of rooms 207 and 232 were sharp wooden edges d 268 B had a huge amount of itter, in boxes in disarray a numerous black electrical et that looked like spaghetti and o cause an accident or injury.	4			
	11/18/15, indicated difficulty in either c possessions becau	on Hoarding, effective date I "Hoarding is a persistent ollecting or parting with use of a perceived need to oint of creating distress."				
	if able to understar - offer sealed conta resident insists on - assess and addre	anagement: I safety issues with the resident and or with the family/friend; ainers for storage if the storing food in room, ess reasons for hoarding, the resident for another item if				
	contract for not tak	able to understand, create a ing items back to room or for schedule. Identify areas of				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	1	
OLDEN	I LIVINGCENTER - ST	ELOUIS PARK PI	GINIA AVENUE OUIS PARK, MI			
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21665	Continued From pa	age 68	21665			
	come to an agreent back to the room a place. - Limit the availabil tends to take (extra packets, etc.) -Set a routine for cl all possible, this sh present to help dev rather than have th some of his/her obj family/friend/clergy assist. - Reinforce positive - Anticipate needs During the tour, the confirmed the above rooms, splintered h cords in one area. stated that he could electrical cords and handrails could be had a policy on hose maintenance indicate with the residents i organized. SUGGESTED MET DM could review at maintenance staff building disrepair. Director of nursing reporting environm	capable of understanding, nent that if items are brought nother must be returned in its ity of extra items resident a silverware or condiment hecking for hoarded items. If a ould be done with the resident velop a trusting relationship re resident "discover" that jects are missing. Arrange for or other trusted person to the behavior so perceived need is met." e director of maintenance ve observation of cluttered handrails, and multiple electric The director of maintenance d use ties to separate the d tidy up the cords, the sanded, and that the facility arding. The director of ated that staff were to work n keeping the clutter down and THOD OF CORRECTION: The nd revise the policies, educate and identify trends of repeated The DM could work with the (DON) to ensure staff are ental issues appropriately. R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE	01/14/2010	
GOLDEN	I LIVINGCENTER - S		RGINIA AVEN LOUIS PARK,			
(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 COMPLET	
21685	Continued From pa	age 69	21685			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685		2/23/16	
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a f good repair and operation nealth, comfort, safety, and esidents according to a writte ce and repair program.	n			
	by: Based on observat review, the facility f enviroment for 1 of complained of nois to maintain a safe, and homelike envir	ent is not met as evidenced ion, interview, and document failed to prevent a noisy 2 residents (R48) who e. In addition, the facility faile sanitary, free of urine odors, ronment. This had the potenti 5 residents in the facility.		corrected		
	Findings include:					
	admission date 11/ staff members abo noise, no one came now R48 kept the c	nning continuously, since her (13/15. R48 had told several out the running water and the e to fix the running water and door to her bathroom closed s r the running water.	o			
	and when asked at levels, R48 stated anyone, to come in the toilet in her bat was admitted to the water had been rur	wed on 1/11/16, at 2:21 p.m. bout comfort, light, and sound that she wanted someone, and fix the running water in hroom. R48 stated that she e facility on 11/13/15, and the nning nonstop in her toilet sind indicated had told several sta	ce			

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
	PROVIDER OR SUPPLIER	TLOUIS PARK PL 3201 VIF	DDRESS, CITY, S GINIA AVENU OUIS PARK, M	E SOUTH	·	
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	-	21685			
	cares and nothing water. The bathroo was running in the	ome in her room and provide was done to stop the running om was checked and the water toilet and was very noisy.				
	R48's Minimum Data Set dated 11/20/15, indicated R48 was cognitively intact.					
	At the beginning of the tour on 1/14/16, at 10:00 a.m. the director of maintenance was unaware of the noisy toilet and was asked for a maintenance repair request policy and none was provided.					
	through 11:00 a.m. (DM), Administrato and Director of Env	y on 1/14/16 at 10:00 a.m. with the District Manager or, Director of Maintenance, vironmental Services I laundry) the following areas attention:				
	numerous spots th had numerous gou	hallways was worn and had roughout and hallways walls ges and black marks on the units on second floor.				
	behind the bed - Room 209 - the e a deep gouge with - Room 282 missin and a bathroom ha	a large gouge in the wall board entrance door to the room had jagged edge ig tile by the bathroom door, id raised area for the toilet had e upper edge, and the floor was				
	- 211A strong urine	e smell in the bathroom				

<u>Minnesc</u>	ta Department of He	ealth				APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00943	B. WING		01/	14/2016
	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - S		GINIA AVENU DUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21685	Continued From pa	age 71	21685			
	- 233A strong urine - 378 A urine odor					
	after the remodel w completed in 2/16. completed and the and update the sec end of the tour the agreed with the em The Director of Em writer a copy of the 01/16. The carpet on 1/6/16 2E, 1/13/ 1/20/16 Extract 2S Extraction was the	ding projects for the facility vas done on first floor to be The third floor has been hopes would be to remodel cond floor in the future. At the Director of Maintenance vironmental issues as listed. vironmental Services gave the e carpet cleaning schedule for was to have Extract cleaning (16, Extract Center Hall, , and 1/27/16 Extract 2N. process to clean spots in the a were to be done on Fridays ay).				
	The Director of Nur develop, review, ar procedures to ensu- maintained in a saf The Director of Nur educate all appropri- procedures. The Director of Nur	THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure resident's environment is fe, clean and sanitary manner. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
	() ,					
21735		0 Solid Waste Disposal	21735			2/23/16
21735	MN Rule 4658.142	0 Solid Waste Disposal ding garbage, rubbish,	21735			2/23/16

Minnesc	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBE	·р.			(X3) DATE COMP	
		00943		B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST			INIA AVENU JIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULI 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
21735	Continued From pa	ige 72		21735			
21735	recyclables, and oth stored, and dispose create a nuisance of breeding place for in Accumulation of co- unassigned areas is This MN Requirement by: Based on observation review, the facility for containment of gard to prevent attracting the potential to affer the facility. Findings include: On 1/12/16, at 11:1 facility main garbag observed littered wit soiled gloves, used around the main dur main dumpster. On 1/13/16, on a su- the director of dieta same heavily littered day. During the tou another staff were in the dumpster the di- area was heavily littered with a mattress was When asked who we the area the district	her refuse must be collected of in a manner that will be of in a manner that will be of in a manner that will be fire hazard, nor provided insects or rodents. Insustible material or was is prohibited. The is not met as eviden ion, interview, and docum ailed to ensure proper bage in the outside dump g pests and rodents. This ct all 175 residents resided 0 a.m. during a tour to the g dumpster the area was it h slices of bread, multip incontinent products all impster and underneath ubsequent visit to the area ry the area remained the d as noted on the previo r the district manager an in the area walked all arc istrict manager verified the tered around and undernes was responsible for clean istrict manager stated was a g	ill not de a aste in nced ment pster s had ding at the s had ding at the ea with e ous nd ound he neath ster. ning group	21735	corrected		
Minnesota D	ensuring the area w	who was responsible fo vas clean was not really ed was going to have the	able				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00943	B. WING		01/	14/2016
AME OF P	ROVIDER OR SUPPLIER	L	DDRESS, CITY, ST	ATE, ZIP CODE		
OLDEN	LIVINGCENTER - ST		GINIA AVENUE OUIS PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21735	Continued From pa	ge 73	21735			
	stated his staff had garbage was dispo- noticed the area wa to assisting with cle there was no garba Waste Disposal pol indicated "The Dinin hold, transfer and o that does not create for insects and rode transmission of dise to "Keep dumpster and free of debris." SUGGESTED MET The maintenance d develop, review, an procedures to ensu disposal of garbage maintenance direct all appropriate staff procedures. The m	licy reviewed 2/12/15, ng Service department will lispose of waste in a manner e a nuisance or breeding place ents, or otherwise permit the ease." The policy directed staff and dumpster site areas clear THOD OF CORRECTION: lirector or designee could d/or revise policies and re the proper storage and e is maintained. The or or designee could educate on the policies and aintenance director or relop monitoring systems to	e F			
	TIME PERIOD FOR Twenty-One (21) D					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			2/23/16
	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				

Minneso	ta Department of He	ealth				-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00943	B. WING		01/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST		GINIA AVENI DUIS PARK, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y 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	ige 74	21805			
	This MN Requirem	ent is not met as evidenced				
	by: Based on observati review, the facility f dinning for 1 of 1 re	ion, interview, and document ailed to provide dignified esident (R181) observed being g by staff who stood while		corrected		
	Findings include:					
	12/22/15, indicated cognitive impairment assistance with eat	Vinimum Data Set dated the resident had moderate nt and required staff ing. R181's diagnoses brain injury and dementia.				
	encourage indepen resident as needed diet order dated 12/	ated 1/6/16, directed staff to ident eating as able, feed . Speech therapy clarification /21/15, directed staff R181 eed food and honey thick				
	nursing assistant (N R181 pureed turkey and pureed green b	on 1/11/15, at 6:35 p.m. NA)-D was observed feeding y, mashed potatoes with gravy beans and a honey thick as observed standing the as feeding R181.				
	stated, "I thought I of stood while feeding	1/13/16, at 2:55 p.m. NA-D could feed more quickly if I [R181]. I did not talk to er told me I could not stand ident."				
Minnesota D	director of nursing (1/14/16, at 3:00 p.m. the (DON) stated it was her aff would sit while feeding				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - ST		GINIA AVENU OUIS PARK, N			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 75	21805			
	1/26/15, instructed resident feel that the that the procedure complete attention. level as the resider SUGGESTED MET DON or social serv on the need to trea dignity. The Quality committee could de	THOD OF CORRECTION: The ices could in-service all staff t all residents with respect and Assessment and Assurance evelop a system to audit ified care and services toward				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			2/23/16
	residents shall hav medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve thei vsical and mental functioning. where the service is not iblic or private resources.				
	by: Based on observat review, the facility f was within reach as	ent is not met as evidenced ion, interview, and document ailed to ensure the call light nd available for use for 1 of 1 no utilized their call light for		corrected		

If continuation sheet 76 of 83

	ta Department of He					APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/	14/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOLDEN	LIVINGCENTER - S	T LOUIS PARK PI	GINIA AVENU OUIS PARK, M			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 76	21810			
	3 of 4 residents (R appropriate seasor	aff. In addition failed to ensure 19, R153, R181) had n and proper fitting clothing ies for daily living (ADLs)				
	Findings include:					
	during the interview observed laying on bed. When asked if light to ask for help the time. R125 stat at the time. -At 4:11 p.m. licens stated R125 used I staff in. LPN-A wer verified the call ligh it off the floor and p sure it worked and asked if she was a stated "Yes. All the -At 4:13 p.m. when put at reach when nursing assistant (I as he had left the r other NA.	a asked if call light had been observed early assisting R125 NA)-A stated he was not sure oom and was going to ask the	t			
	8/13/15, indicated to coming to nursing used a mechanical for falls with potent injury and further d	ea Assessment (CAA) dated resident had fall prior to home. CAA indicated R125 I lift for all transfers, was at risk tial for fracture and/or serious lebilitation. dated 8/13/15, indicated R125				
	was at risk for falls laceration from fall impaired cognition had generalized wa	, had sustained head s, had history of falls, had , impaired physical ability and eakness. The care plan				
TE FOR	epartment of Health		6899 7	6C411	If continuati	on sheet 77 o

VIDER OR SUPPLIER VIDER OR SUPPLIER VINGCENTER - S SUMMARY ST. (EACH DEFICIENC REGULATORY OR I ontinued From pa ected staff to en ere available and n 1/14/16, at 2:00 rvices (DNS) sta an indicating the reach then it wa ach. Il light policy rev re all call lights a hes, never on the 9 was dressed in her weather and d worn with spece
/INGCENTER - S SUMMARY ST. (EACH DEFICIENC REGULATORY OR I pontinued From particular ected staff to en- ere available and n 1/14/16, at 2:00 rvices (DNS) state an indicating the reach then it wate ach. Il light policy reverses re all call lights a hes, never on the 9 was dressed in hter weather and
/INGCENTER - S SUMMARY ST. (EACH DEFICIENC REGULATORY OR I pontinued From particular ected staff to en- ere available and n 1/14/16, at 2:00 rvices (DNS) state an indicating the reach then it wate ach. Il light policy reverses re all call lights a hes, never on the 9 was dressed in hter weather and
SUMMARY ST. (EACH DEFICIENC REGULATORY OR I pontinued From pare ected staff to en ere available and n 1/14/16, at 2:00 rvices (DNS) state an indicating the reach then it wa ach. Il light policy rev re all call lights a nes, never on the 9 was dressed in ther weather and
(EACH DEFICIENC REGULATORY OR I pontinued From pare ected staff to en ere available and n 1/14/16, at 2:00 rvices (DNS) sta an indicating the reach then it wa ach. Il light policy rev re all call lights a nes, never on the 9 was dressed in ther weather and
ected staff to en ere available and n 1/14/16, at 2:00 rvices (DNS) sta an indicating the reach then it wa ach. Il light policy rev re all call lights a nes, never on the 9 was dressed in nter weather and
ere available and n 1/14/16, at 2:00 rvices (DNS) sta an indicating the reach then it wa ach. Il light policy rev re all call lights a nes, never on the 9 was dressed in ther weather and
rvices (DNS) sta an indicating the reach then it wa ach. Il light policy rev re all call lights a nes, never on the 9 was dressed i nter weather and
re all call lights a nes, never on the 9 was dressed i nter weather and
nter weather and
her bed.
n 1/11/16, at 3:58 served sitting or at came to above pair of gripper so anket, was obser d R19 was noted stril.
n 1/13/16, at 7:29 ting by the dining essed with a thin ir of light weight esident stated that breakfast.
egistered nurse (13/16, at 7:38 a.ı n tee shirt on an
es ir es g

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00943	B. WING		01/	14/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - ST	ELOHIS PARK PI	GINIA AVENU OUIS PARK, M			
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
21810	Continued From pa	age 78	21810			
	addition, RN-B con	nould have been changed. In firmed the resident's linens are ay and R19's bath day was on				
	were changed ever room and saw the l stated, "I will chang clear plastic bag wil as she stripped the NA-G indicated that inserted her finger	a.m. NA-G stated bed linens by bath day. NA-G was in R19's blood on the top blanket and ge the linens now." NA-G had a hich she put the soiled linen in soiled linen from R19's bed. It the resident frequently into a nostril and then put the postril on the bed linen.	L			
	1/13/16, at 12:43 p appointed guardiar	ial services (Dir of SS) on .m. confirmed R19 had a court n, and had no family. The Dir of d R19 did not want to wear a				
	clothing in her close 12:57 p.m. The LS ¹ any underwear in h briefs. R19 had app summer blouses an LSW agreed R19 c clothing in her close call the R19's guard	orker (LSW) reviewed R19's et and dresser on 1/13/16, at W agreed R19 did not have her dresser, only incontinent proximately ten very thin and ten summer pants. The only had a winter coat for winte et. The LSW stated she would dian and review the need for for R19 that was more winter weather.				
	had a history of refu changing clothing a indicated she had s guardian at first wa clothing because s) p.m., the LSW indicated R19 using showers, personal cares and wearing a bra. The LSW spoken to R19's guardian. The is reluctant to spend money on he was spending money on a the resident. However, after	,			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	00943		B. WING		01/14/2016	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
GOLDEN	I LIVINGCENTER - ST		GINIA AVENU DUIS PARK, M			
(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) COMPLET DATE
21810	Continued From pa	age 79	21810			
		ation, R19's guardian indicated e would give the facility money clothing.				
	a.m. and indicated would contact the L need of clothing ap	viewed on 1/14/16, at 10:00 she expected the nurses SW when a resident was in propriate for age, fit, and he LSW would contact the				
	11/17/15, indicated required assistance	inimum Data Set (MDS) dated resident was cognitively intact, e with activities of ADLs, and nent of bowel and bladder.				
	until 10:35 a.m. and - 7:00 a.m. R153 si wearing black pant the abdomen expo black shirt that did a black sweater an	on 1/13/16, from 7:00 a.m. d the following was noted: itting in dining room. R153 s that were unzipped leaving sed. R153 had a gray and not cover abdomen. R153 had d gray blanket over shoulders. ralked by R153 and did not				
	adjust clothing.	valked by R153 and did not ered dietician adjusted R153's				
	with ground sausage with fingers. Abdom without adjusting R - 8:13 a.m. R153 sl	leeping at table, abdomen				
	abdominal fold, top - 8:16 a.m. NA-E p did not adjust R153					
innesota D	- 8:16 a.m. NA-E p did not adjust R153 - 8:17 a.m. LPN-B epartment of Health	oured milk at R153 s table and	6899 7	6C411	If continuatio	

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		DENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00943	B. WING		01/	01/14/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - S	ELOUIS PARK PI	RGINIA AVENU OUIS PARK, M				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21810	Continued From pa	age 80	21810				
	entire abdomen an immediately. - 8:26 a.m. R153's and NA-B walked b clothing. - 8:29 a.m. LPN-B - 8:35 a.m. R153's abdomen. - 8:40 a.m. LPN-B it to cover R153's a On 1/14/16, at 8:10 sitting in the dining black pants. R153's exposed. On 1/14/16, at 12:2 the dining room we	umbilicus exposed, LPN-B by R153 without adjusting adjusted R153's clothing. shirt rolled up to expose unfolded blanket and arranged abdomen, chest and shoulders 0 a.m. R153 was observed room wearing a blue shirt and s abdomen was partially 25 p.m. R153 was observed in earing a blue shirt and black cposed up to the umbilicus.					
	the resident had m and required staff a	MDS dated 12/22/15, indicated oderate cognitive impairment assistance with activities of diagnoses included traumatic mentia.	ł				
	observed in the hat (SLP). R181's shirt plunging V neck. R The SLP had broug with a hospital gow down. The therapis RN-D removed the	1/15, at 5:59 p.m. resident was llway with the speech therapist was very loose with a 1181's abdomen was showing. ght resident back from therapy in draped over her front upside st stated resident was cold. gown and adjusted the shirt terial behind R181's back, so it	3				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/	14/2016	
	PROVIDER OR SUPPLIER	T LOUIS PARK PL 3201 VIR	DDRESS, CITY, ST	E SOUTH	·		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC	SAINT LO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	DUIS PARK, M	N 55426 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21810	showing. RN-D offestated, "I thought I On 1/13/15, at 7:00 sitting in dining roo patterned boat neo - 8:10 a.m. the SLF - 8:24 a.m. the shir which exposed R1 SLP was still worki - 8:40 a.m. R181 w right shoulder was During an interview NA-B said indicate her body. "Most of pull them down and NA-B was also inter and acknowledged think she has lost w beautiful clothing. W the tops she has w On 1/14/16, at 11:4 director-B stated if smaller clothing us contacted to bring director-B stated th had clothing that fit know if a resident of family know. If the I will help the resid the funds, go throu stuff myself. [R153 elastic pants I notice	ered R181 a blanket. R181 was warm." D a.m. R181 was observed m. R181 was wearing a brown k shirt and a red infinity scarf. P was working with R181. t had slipped off right shoulder 81's shoulder exposed. The ng with resident. /as sitting at the table and the exposed. v on 1/14/16, at 11:47 a.m. d R153's clothing did ride up them are too small. We try to d redirect her to larger shirts." erviewed about R181's clothing I the clothes were too big. "I weight. She has a lot of We select the clothing. All of rorn today have been too big." 49 a.m. the Alzheimer care a resident needed larger or ually a family members were clothing. Alzheimer care ne system for ensuring resident ts was "I ask staff to let me needs something then I let the resident does not have family, ent purchase stuff if they have igh lost and found or purchase] went down yesterday and got ced it yesterday. I will call		DEFICIENCY	<u>^</u>		
	[R181] has a guard designer. She likes being well dressed	and follow her guidance. dian. She was a fashion s things this way. We know that was important to her. We will assistant to thin out closet so					

Minnesc	ta Department of He	alth				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00943	B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ST	I OUIS PARK PI	GINIA AVENU DUIS PARK, M			
(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
	around 30 days. I d clothing on that is to team] IDT meetings weekly and ask do On 1/14/16, at 11:4 her Twins shirt and clothing did ride up too small. NA-B sta and redirect her to director." NA-B ack were too big "I think a lot of beautiful clo	thes. She has been here on't know why we have bo big. During [interdisciplinary s we review all residents they need anything." 7 a.m. NA-B stated R153 liked cat shirt. NA-B stated R153 most of time and thought was ited "We try to pull them down larger shirts and have told the nowledged R181's clothes is she has lost weight she has othing. We select the clothing. has worn today have been too				
Minnesota D	big." On 1/14/16, a polic clothing but was no SUGGESTED MET The director of nurs that policy and proc staff are trained and appropriate dress v the achieve their high	y was requesting for resident t provided. THOD OF CORRECTION: sing or designee could assure cedures are up to date, that d that call lights and wear are monitored to assure				