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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 76C4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245148**

2. STATE VENDOR OR MEDICAID NO. (L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

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

6. DATE OF SURVEY **02/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	208			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1968** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00450** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245148 Y1	A. Building B. Wing Y2	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0246	Correction	ID Prefix F0258	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(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(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(c)	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)	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(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	02/23/2016	LSC	02/23/2016	LSC	02/23/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	03/02/2016	18623	2/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245148 Y1	A. Building B. Wing Y2	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0465	Correction	ID Prefix F0514	Correction		
Reg. # 483.70(h)	Completed	Reg. # 483.75(l)(1)	Completed		
LSC	02/23/2016	LSC	02/23/2016		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/14/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245148	A. Building 01 - MAIN BUILDING 01 B. Wing	2/29/2016

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 02/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	03/02/2016	19251	02/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 76C4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245148**

2. STATE VENDOR OR MEDICAID NO. (L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

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

6. DATE OF SURVEY **01/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	208			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Eva Loch, HFE NE II — 02/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 03/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1968** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00450** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by 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

St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ 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 SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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. 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 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: 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. Findings include:	F 241	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	2/23/16

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

Electronically Signed | 02/04/2016

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F 241	Continued From page 1 R181's speech therapy clarification diet order dated 12/21/15, directed staff that R181 was to receive pureed food and honey thick liquids. R181's admission Minimum Data Set dated 12/22/15, indicated the resident had moderate cognitive impairment and required staff assistance with eating. R181's diagnoses included traumatic brain injury and dementia. R181's care plan dated 1/6/16, directed staff to encourage independent eating as able, feed resident as needed. During observation on 1/11/15, at 6:35 p.m. nursing assistant (NA)-D was observed feeding R181 pureed turkey, mashed potatoes with gravy and pureed green beans and a honey thick beverage. NA-D was observed standing the entire time NA-D was feeding R181. During interview on 1/13/16, at 2:55 p.m. NA-D stated, "I thought I could feed more quickly if I stood while feeding [R181]. I did not talk to [R181]. No one ever told me I could not stand while feeding a resident." During interview on 1/14/16, at 3:00 p.m. the director of nursing stated it was her expectation that staff would sit while feeding residents. The facility Eating Support procedure dated 1/26/15, instructed staff: "Never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible."	F 241	state and federal regulatory requirements. F 241 a. R 181 assessment for feeding assistance reviewed and remained current for resident. b. Audit of all residents to identify those that need assistance with feeding. c. All staff that assist with feeding educated to the Eating Support procedure. d. DNS or designee to complete weekly audit of 5 residents receiving eating support for dignified meal experience. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246		2/23/16

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F 246 SS=E	Continued From page 2 OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach and available for use for 1 of 1 resident (R125), who utilized their call light for assistance from staff. In addition failed to ensure 3 of 4 residents (R19, R153, R181) had appropriate season and proper fitting clothing reviewed for activities for daily living (ADLs) Findings include: R125 was observed on 1/11/16, at 4:10 p.m. and during the interview R125's call light was observed laying on the floor at the base of the bed. When asked if she was able to use the call light to ask for help resident stated she used it all the time. R125 stated she was not able to reach it at the time. -At 4:11 p.m. licensed practical nurse (LPN)-A stated R125 used her call light at times to call staff in. LPN-A went to room with surveyor and verified the call light was not at reach, then pulled it off the floor and pushed the button to make sure it worked and handed it to R125. When asked if she was able to use the call light R125 stated "Yes. All the time."	F 246	F 246 a. R125 room rearranged to ensure call light 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 purchase additional clothing that fits appropriately. R181 guardian was contacted and gave permission to sort through clothing with resident and help resident purchase new clothing. b. R125 care plan reviewed and revised 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 plans for accommodation of needs for call light and clothing at next scheduled care conference. c. Educate all staff on call light placement within reach of resident, and identifying residents clothing needs and communicating this to IDT for assistance	

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F 246	Continued From page 3 -At 4:13 p.m. when asked if call light had been put at reach when observed early assisting R125 nursing assistant (NA)-A stated he was not sure as he had left the room and was going to ask the other NA. R125's fall Care Area Assessment (CAA) dated 8/13/15, indicated resident had fall prior to coming to nursing home. CAA indicated R125 used a mechanical lift for all transfers, was at risk for falls with potential for fracture and/or serious injury and further debilitation. The fall care plan dated 8/13/15, indicated R125 was at risk for falls, had sustained head laceration from falls, had history of falls, had impaired cognition, impaired physical ability and had generalized weakness. The care plan directed staff to ensure call light or personal items were available and in easy to reach. On 1/14/16, at 2:00 p.m. the director of nursing services (DNS) stated if a resident had a care plan indicating the call light was supposed to be at reach then it was supposed to have been at reach. Call light policy reviewed 1/8/15, directed staff "Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand." R19 was dressed in inappropriate clothing for winter weather and her bed linens were very thin and worn with specks of blood on the top blanket on her bed. On 1/11/16, at 3:58 p.m. the resident was observed sitting on her bed with a very thin dress	F 246	with purchasing and sorting through clothing. d. ACD or SSD or designee to complete weekly audit of 5 residents for call light placement and clothing needs. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 246	Continued From page 4	F 246		

that came to above the knees. R19 was wearing a pair of gripper socks. The top bed linen, a blanket, was observed to have small blood stains and R19 was noted to be inserting a finger into a nostril.

On 1/13/16, at 7:29 a.m. R19 was observed sitting by the dining room table. R19 was neatly dressed with a thin white tee shirt, no bra and a pair of light weight blue elastic waist band pants. Resident stated that she was hungry and waiting for breakfast.

Registered nurse (RN)-B was interviewed on 1/13/16, at 7:38 a.m. and confirmed R19 had a thin tee shirt on and light weight pants. In addition, RN-B confirmed the blood spots of R19's bed linens and stated that the bed linens should be changed as needed when dirty and R19's bed linens should have been changed. In addition, RN-B confirmed the resident's linens are changed on bath day and R19's bath day was on Monday, 1/11/16.

On 1/13/16, at 7:44 a.m. NA-G stated bed linens were changed every bath day. NA-G was in R19's room and saw the blood on the top blanket and stated, "I will change the linens now." NA-G had a clear plastic bag which she put the soiled linen in as she stripped the soiled linen from R19's bed. NA-G indicated that the resident frequently inserted her finger into a nostril and then put the content from the nostril on the bed linen.

The director of social services (Dir of SS) on 1/13/16, at 12:43 p.m. confirmed R19 had a court appointed guardian, and had no family. The Dir of SS further indicated R19 did not want to wear a bra.

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F 246	Continued From page 5 A licensed social worker (LSW) reviewed R19's clothing in her closet and dresser on 1/13/16, at 12:57 p.m. The LSW agreed R19 did not have any underwear in her dresser, only incontinent briefs. R19 had approximately ten very thin summer blouses and ten summer pants. The LSW agreed R19 only had a winter coat for winter clothing in her closet. The LSW stated she would call the R19's guardian and review the need for additional clothing for R19 that was more appropriate for the winter weather. On 1/13/16, at 2:40 p.m., the LSW indicated R19 had a history of refusing showers, personal cares, changing clothing and wearing a bra. The LSW indicated she had spoken to R19's guardian. The guardian at first was reluctant to spend money on clothing because she was spending money on a music therapist for the resident. However, after additional consideration, R19's guardian indicated to the LSW that she would give the facility money to buy R19 winter clothing. The DNS was interviewed on 1/14/16, at 10:00 a.m. and indicated she expected the nurses would contact the LSW when a resident was in need of clothing appropriate for age, fit, and weather and then the LSW would contact the guardian. R153's quarterly Minimum Data Set (MDS) dated 11/17/15, indicated resident was cognitively intact, required assistance with activities of ADLs, and was always incontinent of bowel and bladder. During observation on 1/13/16, from 7:00 a.m. until 10:35 a.m. and the following was noted:	F 246		

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F 246	Continued From page 6	F 246		

- 7:00 a.m. R153 sitting in dining room. R153 wearing black pants that were unzipped leaving the abdomen exposed. R153 had a gray and black shirt that did not cover abdomen. R153 had a black sweater and gray blanket over shoulders.
- 7:15 a.m. NA-E walked by R153 and did not adjust clothing.
- 7:25 a.m. NA-E walked by R153 and did not adjust clothing.
- 7:55 a.m. a registered dietician adjusted R153's shirt.
- 8:01 a.m. R153's breakfast arrived, pancakes with ground sausage. R153 ate the pancakes with fingers. Abdomen exposed NA-D walked by without adjusting R153's clothing.
- 8:13 a.m. R153 sleeping at table, abdomen exposed from above the umbilicus to under abdominal fold, top of incontinence brief visible.
- 8:16 a.m. NA-E poured milk at R153 s table and did not adjust R153's clothing.
- 8:17 a.m. LPN-B pulled R153's shirt down. The shirt covered the umbilicus but did not cover entire abdomen and started to roll up immediately.
- 8:26 a.m. R153's umbilicus exposed, LPN-B and NA-B walked by R153 without adjusting clothing.
- 8:29 a.m. LPN-B adjusted R153's clothing.
- 8:35 a.m. R153's shirt rolled up to expose abdomen.
- 8:40 a.m. LPN-B unfolded blanket and arranged it to cover R153's abdomen, chest and shoulders.

On 1/14/16, at 8:10 a.m. R153 was observed sitting in the dining room wearing a blue shirt and black pants. R153's abdomen was partially exposed.

On 1/14/16, at 12:25 p.m. R153 was observed in

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F 246	Continued From page 7 the dining room wearing a blue shirt and black pants, abdomen exposed up to the umbilicus. Staff in dining room passing meals. R181's admission MDS dated 12/22/15, indicated the resident had moderate cognitive impairment and required staff assistance with activities of daily living. R181's diagnoses included traumatic brain injury and dementia. Observation on 1/11/15, at 5:59 p.m. resident was observed in the hallway with the speech therapist (SLP). R181's shirt was very loose with a plunging V neck. R181's abdomen was showing. The SLP had brought resident back from therapy with a hospital gown draped over her front upside down. The therapist stated resident was cold. RN-D removed the gown and adjusted the shirt by pulling extra material behind R181's back, so it was not so low cut and abdomen was not showing. RN-D offered R181 a blanket. R181 stated, "I thought I was warm." On 1/13/15, at 7:00 a.m. R181 was observed sitting in dining room. R181 was wearing a brown patterned boat neck shirt and a red infinity scarf. - 8:10 a.m. the SLP was working with R181. - 8:24 a.m. the shirt had slipped off right shoulder which exposed R181's shoulder exposed. The SLP was still working with resident. - 8:40 a.m. R181 was sitting at the table and the right shoulder was exposed. During an interview on 1/14/16, at 11:47 a.m. NA-B said indicated R153's clothing did ride up her body. "Most of them are too small. We try to pull them down and redirect her to larger shirts."	F 246		

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F 246	Continued From page 8 NA-B was also interviewed about R181's clothing and acknowledged the clothes were too big. "I think she has lost weight. She has a lot of beautiful clothing. We select the clothing. All of the tops she has worn today have been too big." On 1/14/16, at 11:49 a.m. the Alzheimer's care director (ACD)-B stated if a resident needed larger or smaller clothing usually a family members were contacted to bring clothing. ACD-B stated the system for ensuring resident had clothing that fits was "I ask staff to let me know if a resident needs something then I let the family know. If the resident does not have family, I will help the resident purchase stuff if they have the funds, go through lost and found or purchase stuff myself. [R153] went down yesterday and got elastic pants I noticed it yesterday. I will call [R153's] guardian and follow her guidance. [R181] has a guardian. She was a fashion designer. She likes things this way. We know that being well dressed was important to her. We will work with nursing assistant to thin out closet so she has a lot of clothes. She has been here around 30 days. I don't know why we have clothing on that is too big. During [interdisciplinary team] IDT meetings we review all residents weekly and ask do they need anything." On 1/14/16, at 11:47 a.m. NA-B stated R153 liked her Twins shirt and cat shirt. NA-B stated R153 clothing did ride up most of time and thought was too small. NA-B stated "We try to pull them down and redirect her to larger shirts and have told the director." NA-B acknowledged R181's clothes were too big "I think she has lost weight she has a lot of beautiful clothing. We select the clothing. All of the tops she has worn today have been too big."	F 246		

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F 246	Continued From page 9 On 1/14/16, a policy was requesting for resident clothing but was not provided.	F 246		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent a noisy enviroment for 1 of 2 residents (R48) who complained of noise. Findings include: R48's toilet was running continuously, since her admission date 11/13/15. R48 had told several staff members about the running water and the noise, no one came to fix the running water and now R48 kept the door to her bathroom closed so she would not hear the running water. R48's was interviewed on 1/11/16, at 2:21 p.m. and when asked about comfort, light, and sound levels, R48 stated that she wanted someone, anyone, to come in and fix the running water in the toilet in her bathroom. R48 stated that she was admitted to the facility on 11/13/15, and the water had been running nonstop in her toilet since then. The resident indicated had told several staff members (but could not remember any names) when they would come in her room and provide cares and nothing was done to stop the running	F 258	F 258 a. The toilet was repaired at the time of the survey, and the resident expressed satisfaction with the repair. b. Preventative maintenance program for bathrooms reviewed and remains current. c. Educate staff to notify maintenance with needed repairs using Building Engines, and educate staff to escalate needed repairs to management as identified. d. ED or designee to complete weekly audit of 5 bathrooms for toilet in good repair. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	2/23/16

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F 258	Continued From page 10 water. The bathroom was checked and the water was running in the 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.	F 258		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		2/23/16

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F 278	Continued From page 11 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 residents (R146, R181) Minimum Data Set (MDS) was coded accurately who was reviewed for accidents and toileting. Findings include: R146's admission MDS dated 10/8/15, indicated resident was coded as wandering and was at risk for getting to dangerous places. In addition, R146 was admitted to the facility on 10/1/15, from the hospital with diagnoses including dementia without behavioral disturbance, non-traumatic chronic subdural hemorrhage and laceration without foreign body of scalp. During review of the interdisciplinary notes dated 10/1/15 through 10/19/15, revealed no documentation of resident wandering to dangerous places as on most times resident had one on one supervision. The care plan dated 10/2/15, indicated resident has diagnosis of Alzheimer's or related dementia, had cognitive loss, diminished decision-making capabilities and safety and security issues and had placement in the secure Alzheimer's Care unit. Care plan directed staff to allow resident to walk throughout the unit at will. On 1/14/16, at 7:54 a.m. registered nurse (RN)-A MDS coordinator verified the admission MDS	F 278	F 278 a. The MDS for R146 was modified to reflect accurate wandering status. R 181 MDS will be reviewed and modified as identified. b. MDS are completed according to the RAI manual. c. Education of staff responsible for completion of sections E. Education of staff responsible for completion of section G. All staff education related to behavior and ADL documentation in the medical record. d. DRA or designee will complete weekly audit of 5 MDS for accuracy of section E for wandering and G for toileting assistance. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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10/1/15, had been coded as such and indicated the Alzheimer's care director (ACD) had completed that section of the MDS.

On 1/14/16, at 8:48 a.m. RN-E reviewed the interdisciplinary notes and verified there was no documentation during the assessment period of resident wandering around the unit and to dangerous places.
-At 8:49 a.m. ACD verified MDS coding, stated he thought resident's behavior did put him in a dangerous situation to wander into unsafe areas such as the stairway thus coded the MDS as wandering and at risk to getting to dangerous places.
-At 9:16 a.m. ACD acknowledged he had coded the MDS using the admission information and he did not have any documentation completed at the facility. ACD stated he had just been hired to his position at the time resident MDS was completed and indicated resident MDS was one of the first MDS's he had completed and was open to learning.

According to the Long Term Care Facility Resident Assessment Instrument User's version 3.0 dated October 2015, under the section of Steps for Assessment for Wandering directed staff to:
"1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period. Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to his or her physical or safety needs. The resident may have a purpose such as searching to find something, but he or she

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F 278	Continued From page 13 persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff know is deceased). 2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period." R146's MDS was inaccurately coded for wandering. 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 then taken back to their room for 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. R181's admission MDS dated 12/22/15, indicated resident was coded "8" toileting assistance did not occur during the assessment reference period. In addition, R181 was admitted to the facility on 12/15/15, from the hospital with diagnoses including dementia without behavioral disturbance, traumatic subdural hemorrhage per the MDS. The care plan dated 1/12/16, indicated the resident was incontinent of bowel and bladder and was a check and change every two hours and as needed.	F 278		

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F 278	Continued From page 14 On 1/13/16, at 2:47 p.m. nursing assistant-B revealed R181 was a check and change every two hours. On 1/14/16, at 10:43 a.m. the director of nursing services stated she would expect the staff when completing all MDS to be coded accurately and to ensure correct data was used. The MDS 3.0 manual dated 10/15, directed staff to code the MDS as to "How resident uses the toilet room, commode bedpan, or urinal; transfers on and off the toilet; cleanses self after elimination changes pad; manages ostomy or catheter; and adjusts clothes. Do not emptying of bedpan, urinal, bedside commode, catheter bag, or ostomy bag." R181's MDS was inaccurately coded for toileting.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		2/23/16

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F 279	Continued From page 15 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan for 1 of 2 residents (R187) who used a blood thinner and reviewed for unnecessary medications. Findings include: On 1/14/16, at 12:20 p.m. when approached and asked about her medications, R187 stated she knew most of her medications. R187 stated she did and told surveyor she had received the injections for about six years and had started when she was pregnant at the time. R187 stated she was aware of the side effect from using the Lovenox (used to prevent deep vein thrombosis (DVT) which can lead to blood clots) such as bruising and stated her abdomen was much bruised. R187 stated the staff did all the administration and her husband did help her in the past. Review of R187's December 2015 to 1/14/16, treatment and medication administration records did not indicate anticoagulant side effect monitoring including risk for bleeding and bruising. Review of the Nurses notes dated 12/20/15 to 1/14/16, revealed no bruises had not been addressed even though resident was able to verbalize how she had sustained them.	F 279	F 279 a. R 187 care plan was reviewed and updated to reflect anticoagulation. b. Audit of all residents care plans that are on anticoagulation. c. Education of staff responsible for care plan implementation for anticoagulation. d. DNS or designee completes weekly audit of 5 residents for anticoagulation care plan in place. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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R187's diagnoses included personal history of other venous thrombosis and embolism, essential (primary) hypertension, atrial fibrillation, personal history of pulmonary embolism and long term (current) use of anticoagulants obtained from the Electronic Medication Record dated January 2015.

Review of the care plan dated 4/23/15, revealed R187 had "Altered skin integrity non pressure related..." however, did not indicate R187 had the potential for bruising related to anticoagulation therapy identified/addressed in the care plan.

The Physician Order dated 10/5/15, indicated R187 had an order for Enoxaparin Sodium (Lovenox) solution milligram/milliliter (mg/ml) 100 mg subcutaneously every 12 hours for thromboembolism prevention.

On 1/14/16, at 12:56 p.m. registered nurse (RN)-C stated usually for any resident who was on a blood thinner such as Coumadin or Lovenox the facility had a standard order put in the electronic medication administration record (EMAR) for the nurses to check every shift. RN-C stated usually there was no care plan for it as the staff were already signing off on the side effects in the EMAR.
-At 1:00 p.m. RN-B approached stated "It should be" when asked if a care plan was supposed to be developed when someone was on a blood thinner such as R187. RN-B verified the current care plan and even previous cares plans had not addressed R187 potential for bruising and bleeding.

On 1/14/16, at 2:00 p.m. the director of nursing services (DNS) stated a care plan was supposed

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F 279	Continued From page 17 to have been developed for R187 if resident had been identified as using a blood thinner. Anticoagulant Therapy Guideline last reviewed 01/22/2015, directed staff: · Complete an Immediate Plan of Care (IPOC) within 24 hours following initiation of anticoagulation therapy. · Integrate interventions from IPOC into comprehensive plan of care upon completion of interdisciplinary care plan meeting ..." In addition, the policy indicated for the facility to demonstrate satisfactory monitoring/compliance an immediate plan of care was to be individualized and a physical observation showed plan was implemented."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 3 of 4 residents (R13, R153, R181) reviewed for bowel and bladder incontinence and for 2 of 3 residents (R153, R181) for reviewed repositioning. Findings include: Toileting: R13's room was observed on 1/14/16, at 7:16	F 282	F 282 a. R 13 and R 181 for toileting, and R 153 for toileting and repositioning. Assessments related to alteration in bowel and bladder, and repositioning for identified residents will be reviewed and revised as identified. b. All residents assessments for alteration of bowel and bladder and repositioning will be reviewed at next scheduled care conference.	2/23/16

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F 282	Continued From page 18 a.m. Upon entering R13's room strong urine smell was noted but R13 was not in the room at the time. At 7:17 a.m. when asked what time resident had been assisted to get ready for the day nursing assistant (NA)-B stated he had assisted the resident as R13 had been up at 6:45 a.m. During continuous observation to 10:05 a.m. R13 was not toileted or offered to be checked and change for three hours and 15 minutes. On 1/14/15, at 10:15 a.m. NA-B acknowledged resident had not been toileted timely and was over one hour and 15 minutes from when resident had last been checked and changed. NA-B stated "We are under staffed and some of the residents in the unit need two staff with transfers because they use the transfer machine and some are combative and if two aides go into the room for half hour they is no way I can tell another resident in the middle of cares I have to go now. Someone can point a finger at me but we are under staffed and for 27 residents for two aides with heavy cares it's impossible. I have not even take a 15 minute break and in 20 minutes will be lunch here coming and I am shaking." -At 10:26 a.m. licesned practical nurse (LPN)-B stated NA's were supposed to follow the plan of care and were supposed to toilet the resident timely. LPN-B further stated she would have expected NA-B to report to her he was running late to toilet and resident had refused and she would have attempted to re-approach resident as she did. R13's urinary Incontinence indwelling catheter Care Area Assessment (CAA) dated 10/14/15, identified resident was incontinent of bowel and bladder, was at risk for urine body odor, urinary tract infections and skin breakdown. R13's care	F 282	c. Policy and procedure for alteration in bowel and bladder, and skin integrity reviewed and remains current. Education to staff on assistance provided as care planned utilizing care sheets. d. DNS or designee complete weekly audit of 5 residents for incontinence and repositioning. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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plan dated 11/13/14, identified resident had a functional incontinence of bladder and bowel. Care plan directed staff to provide assistance of one to toilet. Use briefs/pads for incontinence protection and to toilet resident every two hours 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.

R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. and R153 was not toileted for at least three hours. At 10:09 a.m. 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, "No." At 10:19 a.m. NA-B brought R153 to room after asking permission. At 10:25 a.m. NA-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. There was a strong odor of urine present when R153 was lying in bed. registered nurse (RN)-D was present and verified the 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 with urine and RN-D verified the brief was saturated. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. NA-D washed R153's peri area from back to front, then applied new incontinence brief.

The Alteration in Elimination of Bowel and Bladder, Incontinence of bowel and bladder care plan dated 6/29/15, instructed staff to check and change resident every two hours and as needed.

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Care plan dated 11/18/15, indicated R153 had a physical functioning deficit related to self-care impairment, and mobility impairment. Care plan goals were that R153 would be clean, dry, and odor free. Care plan instructed staff that R153 required extensive assist of one for dressing, personal hygiene, bathing, and toileting. It also indicated R153 had a history of refusing some ADL assistance depending on mood.

The undated nursing assistant assignment sheet for R153 instructed staff that R153 was 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.

Bladder assessment dated 12/22/15, indicated R181 had functional urinary incontinence and was not appropriate for toileting or retraining program because of dementia and immobility.

The care plan dated 1/12/16, indicated resident

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was functionally incontinent of bowel and bladder. It instructed staff to check and change R181 every two and as needed.

Undated nursing assistant assignment sheet for R181 instructed staff that R181 was incontinent and was to be checked and change every two hours and as needed.

During interview on 1/13/16, at 9:49 a.m. NA-B said, "[R153] was our third resident to get up. We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities and had not been asked or refused that morning. [R181] was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11 a.m. Then at 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting."
- At 9:56 a.m. LPN-B said R153 was to be repositioned every two hours and check and change every two hours. R153 could also ask to be changed. LPN-B acknowledged R153 had not been toileted in over two hours. LPN-B stated LPN-B would have someone take care of it right away. R181 was to be checked and change every two hours.
- At 10:11 a.m. NA-E stated we got R153 up around 6:30 a.m.
- At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours and offered to be changed every two hours.
- At 2:47 p.m. NA-B stated was working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes

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F 282	Continued From page 22 and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." NA-D said, "I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick." - At 9:22 a.m. the director of nursing services (DNS) said, "I expect the staff to follow our policy regarding incontinence care I expect them to check and change residents in accordance to their care plans." R153 and R181 was not provided incontinent cares according to the plan of care. Repositioning: 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, 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 9:49 a.m. R153 sitting in activity room. - At 10:09 a.m. 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, "No." - At 10:19 a.m. NA-B brought R153 to room after asking permission. - At 10:25 a.m. 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 was present and verified the coccyx was red and	F 282		

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F 282	Continued From page 23 not blanchable. The Pressure Ulcer CAA dated 6/26/15, indicated "CAA triggered for pressure r/t Hx [history of] of CVA [stroke] with weakness, res. is incontinent, requires staff assistance with bed mobility/cares, see MDS ADL/continence coding. Res. [resident] is at risk for pressure, infection, pain and overall decline." The care plan revised 1/12/16, indicated pressure ulcer present to right heel - suspected deep tissue injury. Ulceration to left lateral malleolus. Interventions included heel boots to be worn while resident was in bed and had specialized boots that are stationary in wheelchair, provided by therapy, float heels while in bed, offload every two hours. R181 was observed on 1/13/16, from 7:00 a.m. until 8:55 a.m. for repositioning. - At 7:00 a.m. R181 was sitting in dining room. Mechanical lift sling under R181. - At 7:45 a.m. NA-B sat down and talked with R181 - At 7:56 a.m. breakfast was delivered to R181 and NA-B started to feed R181. - At 8:10 a.m. speech therapy working with R181 at the dining room table. - At 8:46 a.m. NA-D pulled R181 out of dining room and took to room. NA-D and NA-E transferred R181 from wheelchair to bed using a mechanical lift. The peri area was observed to be red from front to approximately four centimeter cm above the rectum. When NA-D touched skin, area blanched. NA-D put R181's pants and blue boots on.	F 282		

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	245148	A. BUILDING _____ B. WING _____	01/14/2016

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F 282	Continued From page 24	F 282		

Urinary incontinence CAA dated 12/24/15, indicated "CAA triggered dr/t [sic- d/t due to] urine incontinence. Res [resident] is at risk for skin break down, UTI. Proceed to care plan to ensure staff aware and provide care PRN [as needed]. Update MD [medical doctor] NP [nurse practitioner] PRN."

The plan off care initiated on 1/6/16, directed staff to turn and reposition R181 every two hours.

During interview on 1/13/16, at 9:49 a.m. NA-B said R153 was the third resident to get up. "We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities, has not been asked or refused this morning. [R181] was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11 a.m. Then 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting."
- At 9:56 a.m. LPN-B said (R153) was to be repositioned every two hours. LPN-B acknowledged R181 was to be repositioned every two hours.
- At 10:11 a.m. NA-E stated, "We got [R153] up around 6:30 a.m."
- At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures." RN-D stated R181 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures."
- At 2:47 p.m. NA-B stated they were working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to

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F 282	Continued From page 25 be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said, "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." The undated Golden Clinical Services Skin integrity Guideline instructed staff to "reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care" and "Care plan is to be implemented, evaluated and revised based on the needs of the resident."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 4 resident (R153) who was incontinent of stool. Findings include:	F 312	F 312 a. R 153 assessment relating to alteration of bowel and bladder will be reviewed and revised. b. All residents assessments for alteration of bowel and bladder will be reviewed at next scheduled care	2/23/16

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F 312	Continued From page 26 R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. and R153 was not toileted for at least three hours. 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, "No." At 10:19 a.m. NA-B brought R153 to room after asking permission. At 10:25 a.m. NA-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. There was a strong odor of urine present when R153 was lying in bed. Registered nurse (RN)-D was present and verified the 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 with urine and RN-D verified the brief was saturated. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. NA-D washed R153's peri area from back to front, then applied new incontinence brief. Bladder assessment dated 6/15/15 and reviewed 11/17/15, indicated resident was not appropriate for bowel and bladder retraining program due to diagnosis of dementia, psychosis and unspecified cerebrovascular disease. Staff was to toilet R153 every 2 hours and as needed. The Urinary Incontinence Care Area Assessment (CAA) dated 6/26/15, indicated, "CAA triggered for incontinence r/t [related to] res. [resident] is incontinent of bowel and bladder, see MDs ADL/continence coding. Res. is at risk for UTI [urinary tract infection], Skin CAA triggered for incontinence r/t res. is at risk for UTI, skin breakdown, unmet hygiene needs."	F 312	conference. c. Policy and procedure for alteration in bowel and bladder reviewed and remains current. Education to staff on assistance provided as care planned utilizing care sheets. d. DNS or designee complete weekly audit of 5 residents for incontinence. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 312	Continued From page 27	F 312		

The Alteration in Elimination of Bowel and Bladder, Incontinence of bowel and bladder care plan dated 6/29/15, instructed staff to check and change resident every two hours and as needed.

Care plan dated 11/18/15, indicated R153 had a physical functioning deficit related to self-care impairment, and mobility impairment. Care plan goals were that R153 would be clean, dry, and odor free. Care plan instructed staff that R153 required extensive assist of one for dressing, personal hygiene, bathing, and toileting. It also indicated R153 had a history of refusing some ADL assistance depending on mood.

The undated Nursing Assistant Assignment Sheet for R153 instructed staff that R153 was incontinent of bowel and bladder and was to be checked and change every two hours.

During interview on 1/13/16, at 9:49 a.m. NA-B said, "[R153] was our third resident to get up. We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities and had not been asked or refused that morning.
- At 9:56 a.m. licensed practical nurse (LPN)-B said R153 was to be repositioned every two hours and check and change every two hours. R153 could also ask to be changed. LPN-B acknowledged R153 had not been toileted in over two hours. LPN-B stated LPN-B would have someone take care of it right away.
- At 10:11 a.m. NA-E stated we got R153 up around 6:30 a.m.
- At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours and offered to be changed every two hours.
- At 2:47 p.m. NA-B stated was working a double. NA-B stated, "Right now we are short staffed."

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F 312	Continued From page 28 When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said, "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." NA-D said, "I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick." - At 9:22 a.m. the director of nursing services said, "I expect the staff to follow our policy regarding incontinence care I expect them to check and change residents in accordance to their care plans." R153 was not provided incontinent cares according to the plan of care. A bowel assessment requested but not provided. Facility procedure Incontinence Management/Bladder Function Guideline effective date 1/19/15, Indicated the purpose of a bladder management program is to: ..."Manage urinary incontinence, restore or maintain as much as normal bladder function as possible." The section "Choosing A Program That Fits The Resident After Evaluation:" instructed staff, "If resident is unsuccessful at toilet training or is unable to participate in retraining than the resident should be placed on incontinence care program. Absorbent products and external collection devices will be used as per center policy in conjunction with incontinence care. Changing programs are also driven by patterns of incontinence." The facility provided procedure lacked instructions regarding the development of	F 312		

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F 312	Continued From page 29 careplan or instruction to nursing assistants on bowel care.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This 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, 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 9:49 a.m. R153 sitting in activity 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	F 314	F 314 a. R 153 and R 181 for repositioning. Assessments related to repositioning for cited residents will be reviewed and revised as identified. b. All residents assessments for skin integrity will be reviewed at next scheduled care conference. c. Policy and procedure for skin integrity, and skin integrity reviewed and remains current. Education to staff on assistance provided as care planned utilizing care sheets. d. DNS or designee complete weekly audit of 5 residents for repositioning. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	2/23/16

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F 314	Continued From page 30	F 314		

be changed. (NA-E asked quietly) R153 said, "No."
- At 10:19 a.m. NA-B brought R153 to room after asking permission.
- At 10:25 a.m. 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. Registered nurse (RN)-D was present and verified the coccyx was red and not blanchable.

The Pressure Ulcer Care Area Assessment (CAA) dated 6/26/15, indicated "CAA triggered for pressure r/t [related to] Hx [history of] of CVA [stroke] with weakness, res. is incontinent, requires staff assistance with bed mobility/cares, see MDS [Minimum Data Set] ADL[activities of daily living]/continence coding. Res. [resident] is at risk for pressure, infection, pain and overall decline."

The Comprehensive Skin Assessment dated 9/22/15,indicated R153 had a current ulcer right and left heels and a history of pressure ulcer on buttock. Intervention indicated reposition every two hours.

R153's quarterly MDS dated 11/17/15, indicated resident was cognitively intact, required assistance with ADLs, and was always incontinent of bowel and bladder. R153's diagnoses listed quarterly MDS included stroke, psychosis and mood disorder.

The care plan revised 1/12/16, indicated pressure ulcer present to right heel - suspected deep tissue injury. Ulceration to left lateral malleolus. Interventions included heel boots to be worn while

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F 314	Continued From page 31	F 314		

resident was in bed and had specialized boots that are stationary in wheelchair, provided by therapy, float heels while in bed, and offload every two hours.

The undated Nursing Assistant Assignment Sheet for R153 instructed staff that R153 turning and repositioning schedule was R153 required assist of two with off loading and transfers using a large sling and mechanical lift. R153 was to have boots on feet while in be and in wheel chair.

R181 was observed on 1/13/16, from 7:00 a.m. until 8:55 a.m. for repositioning.
- At 7:00 a.m. R181 was sitting in dining room. Mechanical lift sling under R181.
- At 7:45 a.m. NA-B sat down and talked with R181
- At 7:56 a.m. breakfast was delivered to R181 and NA-B started to feed R181.
- At 8:10 a.m. speech therapy working with R181 at the dining room table.
- At 8:46 a.m. NA-D pulled R181 out of dining room and took to room. NA-D and NA-E transferred R181 from wheelchair to bed using a mechanical lift. The peri area was observed to be red from front to approximately four centimeter cm above the rectum. When NA-D touched skin, area blanched. NA-D put R181's pants and blue boots on.

Urinary Incontinence CAA dated 12/24/15, indicated "CAA triggered dr/t [sic] urine incontinence. Res is at risk for skin break down, UTI [urinary tract infection]. Proceed to care plan to ensure staff aware and provide care PRN [as needed]. Update MD [medical doctor] NP [nurse practitioner] PRN."

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F 314	Continued From page 32	F 314		

The plan off care initiated on 1/6/16, directed staff to turn and reposition R181 every two hours.

During interview on 1/13/16, at 9:49 a.m. NA-B said R153 was the third resident to get up. "We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities, has not been asked or refused this morning. [R181] was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11 a.m. Then 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting."
- At 9:56 a.m. LPN-B said (R153) was to be repositioned every two hours. LPN-B acknowledged R181 was to be repositioned every two hours.
- At 10:11 a.m. NA-E stated, "We got [R153] up around 6:30 a.m."
- At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures." RN-D stated R181 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures."
- At 2:47 p.m. NA-B stated they were working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?"
- At 2:55 p.m. NA-D said, "I don't always have time to do the repositioning and toileting every

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F 314	Continued From page 33 two hours. We are so busy right now. We do our best." The undated Golden Clinical Services Skin integrity Guideline instructed staff to "reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care" and "Care plan is to be implemented, evaluated and revised based on the needs of the resident."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with incontinence care for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence. Findings include: On 1/11/16, at 2:46 p.m. during room observation	F 315	F 315 a. R 13 and R 153 and R 181 assessment relating to alteration of bowel and bladder will be reviewed and revised. b. All residents assessments for alteration of bowel and bladder will be reviewed at next scheduled care conference. c. Policy and procedure for alteration in	2/23/16

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F 315	Continued From page 34 R13's room was noted to have a musty urine smeel in the room. On 1/13/16, at 6:47 a.m. during a subsequent visit to the room a strong smell of air fresher was noted in the room which masked the urine smell. On 1/14/16, at 7:16 a.m. upon entering R13's room strong urine smell was noted but R13 was not in the room at the time. At 7:17 a.m. when asked what time resident had been assisted to get ready for the day nursing assistant (NA)-B stated 6:45 a.m. At 7:18 a.m. when approached R13 smiled and was talking to surveyor but was heard to be understood. At 7:51 a.m. to 9:12 a.m. R13 remained at the dining room table for breakfast. At 9:12 a.m. R13 was observed seated on wheelchair outside her room. At 9:20 a.m. licensed practical nurse (LPN)-B was wheeled R13 down the hallway to the television (TV) lounge. At 9:25 a.m. R13 was observed wheeling herself down the hallway wandering, appeared lost and confused. At 9:29 a.m. NA-B was observed approach R13 and wheeled resident down the hallway to room. At 9:33 a.m. NA-B and NA-C approached resident. Then NA-B handed a communication card to resident to read and resident nodded her head then both staff wheeled resident into the bathroom. When NA-B was re-directing resident to use the grab bar resident then attempted to grab NA-B. Both NA's were observed attempt to pursuade 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. During observation both NA's never offered to check and change R13 which was two hours and 45 minutes. -At 9:36 a.m. NA-B wheel resident into the TV	F 315	bowel and bladder reviewed and remains current. Education to staff on assistance provided as care planned utilizing care sheets. d. DNS or designee complete weekly audit of 5 residents for incontinence. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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lounge and left. At 9:37 a.m. when approached a strong urine smell was noted on resident. At 9:40 a.m. R13 was observed self transfer to a regular chair in the TV lounge. At 9:44 a.m. R13 again self transfer back to the wheelchair then was observed wheeling down the hallway towards the nursing station.
-At 9:47 a.m. R13 was observed seated on wheelchair across from the nursing station.
-At 9:50 a.m. surveyor approached LPN-B requested to have resident toileted.
-At 9:56 a.m. both LPN-B and NA-B went to room attempted to get resident stand in the toilet but resident was still attempting to grab on male staff NA-B.
-At 10:04 a.m. LPN-B finally suggested to lay resident down in bed to change resident which was 3 hours and and 15 minutes.
-At 10:05 a.m. LPN-B and NA-B assisted resident to bed and as resident stood up LPN-B stated "you needed it." R13's pants and incontinent pad were observed soaked with urine. At 10:13 a.m. LPN-B checked the wheelchair cushion stated "it's a little bit wet."

On 1/14/15, at 10:15 a.m. NA-B acknowledged resident had not been toileted timely and was over one hour and 15 minutes from when resident had last been checked and changed. NA-B stated "We are under staffed and some of the residents in the unit need two staff with transfers because they use the transfer machine and some are combative and if two aides go into the room for half hour they is no way I can tell another resident in the middle of cares I have to go now. Someone can point a finger at me but we are under staffed and for 27 residents for two aides with heavy cares it's impossible. I have not even take a 15 minute break and in 20 minutes

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will be lunch here coming and am shaking."
-At 10:26 a.m. LPN stated NA's were supposed to follow the plan of care and were supposed to toilet the resident timely. LPN-B further stated she would have expected NA-B to report to her he was running late to toilet and resident had refused and she would have attempted to re-approach resident as she did.

R13's diagnoses included schizoaffective disorder, unspecified hearing loss, cerebral infarction without residual deficits, unspecified osteoarthritis, unspecified dementia with behavioral disturbance and conduct disorder obtained from the admission record dated 1/14/16.

R13's Urinary Incontinence Indwelling Catheter Care Area Assessment (CAA) dated 10/14/15, identified resident was incontinent of bowel and bladder, was at risk for urine body odor, urinary tract infections and skin breakdown. R13's care plan dated 11/13/14, identified resident had a functional incontinence of bladder and bowel. Care plan directed staff to provide assistance of one to toilet. Use briefs/pads for incontinence protection and to toilet resident every two hours 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.

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R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. and R153 was not toileted for at least three hours. At 10:09 a.m. 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, "No." At 10:19 a.m. NA-B brought R153 to room after asking permission. At 10:25 a.m. NA-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. There was a strong odor of urine present when R153 was lying in bed. registered nurse (RN)-D was present and verified the 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 with urine and RN-D verified the brief was saturated. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. NA-D washed R153's peri area from back to front, then applied new incontinence brief.

Bladder assessment dated 6/15/15, and reviewed 11/17/15, indicated resident was not appropriate for bowel and bladder retraining program due to diagnosis of dementia, psychosis and unspecified cerebrovascular disease. Staff was to toilet R153 every two hours and as needed.

The Urinary Incontinence CAA dated 6/26/15, indicated, "CAA triggered for incontinence r/t [related to] res. [resident] is incontinent of bowel and bladder, see MDs [sic- Minimum Data Set] ADL [activities of daily living]/continence coding. Res. is at risk for UTI [urinary tract infection], Skin CAA triggered for incontinence r/t res. is at risk for UTI, skin breakdown, unmet hygiene needs."

The Alteration in Elimination of Bowel and

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Bladder, Incontinence of bowel and bladder care plan dated 6/29/15, instructed staff to check and change resident every two hours and as needed.

R153's quarterly MDS dated 11/17/15, indicated resident was cognitively intact, required assistance with ADLs, and was always incontinent of bowel and bladder. R153's diagnoses listed quarterly MDS included Stroke, psychosis and mood disorder.

Care plan dated 11/18/15, indicated R153 had a physical functioning deficit related to self-care impairment, and mobility impairment. Care plan goals were that R153 would be clean, dry, and odor free. Care plan instructed staff that R153 required extensive assist of one for dressing, personal hygiene, bathing, and toileting. It also indicated R153 had a history of refusing some ADL assistance depending on mood.

The undated Nursing Assistant Assignment Sheet for R153 instructed staff that R153 was 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 taken back to their room for 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

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urine. NA-D verified brief was saturated with urine.

The Bladder Assessment dated 12/22/15, indicated R181 had functional urinary incontinence and was not appropriate for toileting or retraining program because of dementia and immobility.

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. R181's diagnoses included traumatic brain injury and dementia.

Urinary Incontinence CAA dated 12/24/15, indicated "CAA triggered dr/t [sic] urine incontinence. Res is at risk for skin break down, UTI. Proceed to care plan to ensure staff aware and provide care PRN [as needed]. Update MD [medical doctor] NP [nurse practioner] PRN."

The care plan dated 1/12/16, indicated resident was functionally incontinent of bowel and bladder. It instructed staff to check and change R181 every two and as needed.

the undated Nursing Assistant Assignment Sheet for R181 instructed staff that R181 was incontinent and was to be checked and change every two hours and as needed.

During interview on 1/13/16, at 9:49 a.m. NA-B said, "[R153] was our third resident to get up. We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities and had not been asked or refused that morning. [R181] was our first resident to get up at 6:10 a.m.

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F 315	Continued From page 40 [R181] is laid down and changed after breakfast then at 11 a.m. Then at 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting." - At 9:56 a.m. LPN-B said R153 was to be repositioned every two hours and check and change every two hours. R153 could also ask to be changed. LPN-B acknowledged R153 had not been toileted in over two hours. LPN-B stated LPN-B would have someone take care of it right away. R181 was to be checked and change every two hours. - At 10:11 a.m. NA-E stated we got R153 up around 6:30 a.m. - At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours and offered to be changed every two hours. - At 2:47 p.m. NA-B stated was working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." NA-D said, "I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick." - At 9:22 a.m. the director of nursing services said, "I expect the staff to follow our policy regarding incontinence care I expect them to check and change residents in accordance to their care plans." R153 and R181 was not provided incontinent cares.	F 315		

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F 315	Continued From page 41 Facility procedure Incontinence Management/Bladder Function Guideline effective date 1/19/15, Indicated the purpose of a bladder management program is to:..." Manage urinary incontinence, restore or maintain as much as normal bladder function as possible". The section "Choosing A Program That Fits The Resident After Evaluation: "Instructs staff If resident is unsuccessful at toilet training or is unable to participate in retraining than the resident should be placed on incontinence care program. Absorbent products and external collection devices will be used as per center policy in conjunction with incontinence care. Changing programs are also driven by patterns of incontinence." The undated Golden Clinical Services Skin integrity Guideline instructed staff to "reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care" and "Care plan is to be implemented, evaluated and revised based on the needs of the resident."	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		2/23/16

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain handrails that were free of splinters on outside of rooms 207 (2N had 29 residents) and 232 (2S had 30 residents which could have been affected), staff, and visitors on the units, a clutter free environment in room 240B and 268B, and tangled electrical cords in room 383B and had the potential to cause 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: - Handrails outside of rooms 207 and 232 were splintered and had sharp wooden edges - Rooms 240 B and 268 B had a huge amount of personal items, clutter, in boxes in disarray - Room 383B had a numerous black electrical cords near an outlet that looked like spaghetti and had the potential to cause an accident or injury. The facility's policy on Hoarding, effective date 11/18/15, indicated "Hoarding is a persistent difficulty in either collecting or parting with possessions because of a perceived need to save them to the point of creating distress." "For immediate management: - review health and safety issues with the resident if able to understand or with the family/friend; - offer sealed containers for storage if the	F 323	F 323 a. Handrails on 2nd floor will be inspected and repaired for splinter free. Rooms 240b and 268b will be assisted to pack up belonging and rearrange for clutter free. Room 383b cords have been arranged for safety. b. Preventative maintenance program in place for identification and repair of safety and accident concerns. The ED or designee is responsible to complete routine environmental rounds to identify safety and accident concerns. c. Education to staff on identification of accident and safety concerns and notification to maintenance or management to address safety and accident hazards related to handrails, cords, and clutter in rooms. d. ED or designee to complete weekly audits of 1 unit and 5 rooms for handrails splinter free and rooms free of clutter and cords. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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resident insists on storing food in room,
- assess and address reasons for hoarding,
- off to "trade" with the resident for another item if necessary."

"For long term management:
- If the resident is able to understand, create a contract for not taking items back to room or for allowing a cleaning schedule. Identify areas of the room appropriate for storage.
- If the resident is capable of understanding, come to an agreement that if items are brought back to the room another must be returned in its place.
- Limit the availability of extra items resident tends to take (extra silverware or condiment packets, etc.)
-Set a routine for checking for hoarded items. If at all possible, this should be done with the resident present to help develop a trusting relationship rather than have the resident "discover" that some of his/her objects are missing. Arrange for family/friend/clergy or other trusted person to assist.
- Reinforce positive behavior
- Anticipate needs so perceived need is met."

During the tour, the director of maintenance was interviewed and confirmed the above observation of cluttered rooms, splintered handrails, and multiple electric cords in one area. The director of maintenance stated that he could use ties to separate the electrical cords and tidy up the cords, the handrails could be sanded, and that the facility had a policy on hoarding. The director of maintenance indicated that staff were to work with the residents in keeping the clutter down and organized.

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F 353	Continued From page 44	F 353		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 1 resident (R181) reviewed for dignified care and services, the facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 4 resident (R153) who was incontinent of stool, for 2 of 3 residents (R153, R181) reviewed for potential skin breakdown, for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence. In	F 353	F 353 a. The assessments and care plans for care and related needs will be reviewed and revised for R 181 for dignified care and services, R 153, R 13, and R 181 for timely assistance with ADLs for incontinence, and R 153 and R 181 for skin integrity and alteration. b. Facility will provide sufficient staffing to provide nursing and related services according to the residents assessments	2/23/16

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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. 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) 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. > Refer to F315: The facility failed to provide timely assistance with incontinence care for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence. Resident Interview:	F 353	and plans of care. c. Education provided to all staff relating to provision of sufficient nursing staffing to meet the residents needs according to assessments and plan of care. Interviews will be completed with sample of residents and staff to help determine opportunities for improvement relating to nursing staffing. Action plans will be implemented based on opportunities identified. d. DNS or designee to complete call light audit and care observations of 5 residents weekly. DNS or designee to interview 5 nursing staff weekly regarding areas of opportunity for sufficient nursing staffing. DNS or designee to interview 5 residents weekly regarding areas of opportunities for sufficient 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.	

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GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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R166's quarterly Minimum Data Set (MDS) dated 10/7/15, indicated R166 had intact cognition required extensive physical assistance of one staff with personal hygiene and was independent with toileting, dressing, transfers and bed mobility. In addition, the MDS indicated R166 used both a walker and wheelchair for mobility.

On 1/11/16, at 4:29 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "Sometimes the staff ignore you and when I have my button for a long time and sometimes I just need ice."

R183's quarterly MDS dated 10/8/15, indicated cognition was moderately impaired and was independent with all activities of daily living (ADLs).

On 1/11/16, at 4:52 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "They are people here who have to wait for a long time and this people are calling for a long time."

R125's quarterly MDS dated 11/10/15, indicated cognition was intact and required extensive physical assistance of one to two staff with bed mobility, dressing, toileting and personal hygiene. In addition, the MDS indicated R125 used a wheelchair for mobility.

On 1/11/16, at 4:05 p.m. during interview when

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F 353	Continued From page 47 asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "Takes a little before they come an hour and can be even longer." R187's quarterly MDS dated 12/10/15, indicated cognition was intact and R187 required limited to extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R187 used a wheelchair for mobility and had no behaviors. On 1/11/16, at 2:59 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "I have had plenty of accidents right now from waiting for staff to assist me. They have me in a pad and I don ' t like them. Before my fall, I was able to transfer myself not anymore. I have had to call them with my phone I don ' t hesitate. This morning we had one aide for 30 residents this floor." R192's quarterly MDS dated 11/7/15, indicated cognition was intact and required limited to extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R192 used a wheelchair for mobility and had a functional limitation in range of motion on one side of the lower extremity. On 1/11/15, at 4:11 p.m. during interview when asked if he felt there was enough staff available	F 353		

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to make sure you get the care and assistance you need without having to wait a long time resident stated staff would go out of the room after answering the call light and would indicate were going to get assistance.

R49's quarterly MDS dated 11/4/15, indicated cognition was moderately impaired and required total to extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R49 used a wheelchair for mobility and had no behaviors.

On 1/12/16, at 9:10 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "Weekends, especially Sunday there is hardly any staff around. I suppose it's my fault for not planning well."

R3's quarterly minimum data set (MDS) indicated R3 was cognitively intact with a diagnosis of schizophrenia.

During interview on 1/13/16, at 12:30 p.m. R3 said they are understaffed here. "It is not a problem for me but it is for other residents especially in the evening or the nights. Staffing concerns are shared at resident council regularly. They told us that was why they could not open the new sub acute unit."

Staff interviews:
On 1/13/16, at 6:14 a.m. licensed practical nurse (LPN)-C stated the shift was usually sometimes

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short staff and had to help the aides with turning and repositioning residents who required two assistance. LPN-C indicated at times it was not possible to finish the workload and had to ask for a pink slip to finish the work. LPN-C further stated most of the times had to prioritize the resident needs and had to have residents wait before their needs were attended to which would be a while.

On 1/13/16, at 6:21 a.m. registered nurse (RN)-F stated the night shift was not short staff but on other shifts when a trained medication aide (TMA) was supposed to work with a nurse most times would not be staffed and the nurse had to do all the work. When asked if the workload was manageable RN-F stated "You can only do the best you can and would ask the supervisor to help and if they don't you do the best." RN-F stated on shifts like those breaks were not taken and resident needs 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."

On 1/13/16, at 7:58 a.m. LPN-D stated usually there were two nurses for 2 South and 2 North and the units shared a TMA who went between the units to pass medications. LPN-D stated at times if the unit was short of an NA the TMA was bumped off the cart and instead at times this

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position was covered by a nurse which LPN-D thought was good as the nurse was able to do a lot more including insulin's. LPN-D stated the units were staffed with two nursing assistants (NAs) and did not think 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.

On 1/13/16, at 7:31 a.m. to 9:10 a.m. during continuous observations at the 2 South nursing station, several residents were overheard walk up to the LPN-E asked for their morning medications. LPN-E was heard re-direct residents and told them she would bring it to them. At 9:18 a.m. when asked if she was running behind with the medication pass LPN-E stated as she smiled "I have not even started." LPN-E was observed on multiple times being interrupted into resident rooms for assist with cares and was leaving the unit to go get pain medications out of the machine located in 2 East which took time away from passing medications timely and the screen windows for some of the residents had even turned red which indicated the medication pass time window had exceeded.

On 1/13/16, at 9:28 a.m. when asked about sufficient nursing NA-F stated it was difficult to get the workload done. When asked if the resident needs were met timely such as repositioning, turning and toileting needs NA-F stated "We try but sometimes we just can't get to it because it is so heavy and the resident ' s requests can be a lot and not being able to get to them timely."
-At 9:35 a.m. the director of nursing services

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(DNS) was apprised of observations of LPN-E working but was not able to get the medication pass going. DNS stated the facility was in the process of hiring a TMA for 2 South and 2 North. DNS verified looking into the computer screen window LPN-E was on the screen for medication administration record red.
-At 9:48 a.m. R46 approached LPN-E and was overheard indicate to LPN-E she was still waiting for her medications. LPN-E acknowledged resident request.
-At 9:50 a.m. after concern was brought to the DNS attention, three nurses were observed to assist LPN-E with the unit medication pass and all the computer screen windows were noted to be red with all the medications that were being in an untimely fashion.
- At 2:47 p.m. NA-B stated was working a double. NA-B stated, "right now we are short staffed." When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You can not always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?"
- At 2:55 p.m. NA-D stated "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best."

On 1/14/16, at 10:15 a.m. NA-B stated "We are under staffed and some of the residents in the unit need two staff with transfers because they use the transfer machine and some are combative and if two aides go into the room for half hour they is no way I can tell another resident in the middle of cares I have to go now. Someone can point a finger at me but we are under staffed

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and for 27 residents for two aides with heavy cares it's impossible. I have not even taken a 15 minute break and in 20 minutes will be lunch here coming and am shaking."
The facility staffing pattern was based on units as follows:
Unit 1 North- Census 23
-Day shift- one nurse manager (NM), two RN, and three NA's
-Evening shift- had one nursing supervisor (SUP) for the building, two 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).
Unit 2 North-Census 29 & 2 South-Census 30
-Day shift one nurse assigned to 2 North and one nurse assigned to 2 South, one TMA who went between 2 North and 2 South to assist with medication administration, three + two and a half (total of 5 1/2) NA's with some varying hours to cover people getting up and dressed, or ready for bed.
- Evening shift- one nurse assigned to 2 North and one nurse assigned to 2 South, one TMA who went between 2 North and 2 South to assist with medication administration, two and a half + two and a half (total of 5) CNA's with varying hours.
-Night shift- one nurse and one NA for each side.
Unit 2 East- Census 50
-Day shift one NM, three nurses, and six NA's
-Evening shift two nurses and one TMA or three nurses, and five NA's
-Night shift two nurses and two NA
Unit ACU Census 27 and AACU Census 25 (staff as one unit).
-Day shift one NM and one nurse on each side 5 NA's with varying hours
-Evening shift one nurse on each side and five

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F 353	Continued From page 53 NA -Night shift one nurse between the sides and two NA's. Weekend supervisor day shift, rotates between the nurse managers, the evening and night supervisors are hired positions (one currently vacant). The daily staffing sheets were reviewed and were nearly unreadable, from the changes and the staff hand written in and show a progressive decline in planned staff (typewritten in), vs hand written in staff. Example, on Wednesday 1/6/16, for the facility, 17 nurses were typewritten onto the schedule and 15 were hand written 46% were added after the schedule was planned; NA's on 1/6/16, 24 were typewritten in and 26 were handwritten in. 52% were added after the schedule was planned. One nursing supervisor did a double from days to evenings and two LPN's did doubles from days to evenings. The facility DNS and staffer felt the facility was able to cover all shifts budgeted hours by changing the composition of the staff when needed (if short a nurse increase TMA or NA hours, if short a NA and unable to fill than increase nurse hours). The DNS had acted as the evening supervisors twice in the past year, with a census over 170. The DNS stated "staff work really well and shifts are getting filled, it's not easy and we are not at optimal staffing every day." The DNS revealed that 60% of RN/LPN FTE (full time equivalent = 80 hour per pay period) was open positions due to the hiring occurring at a nearby hospital. The NA open FTE was 58.1%,	F 353		

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F 353	Continued From page 54 staff were leaving and citing more pay down the street. The facility was in the process of reviewing the wage scale, and benchmarking with the community.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food sanitation procedures were followed to minimize the possibility of food borne illness in the main kitchen and in 6 of 7 kitchenettes. This had the potential to 171 of 175 who were served food and/or fluids out of 6 of 7 kitchenettes and the main kitchen. Findings include: During the kitchen and facility tour on 1/11/16, at 11:48 a.m. to 12:52 p.m. with the director of dietary (DD) the following was observed: - Hobart Stand up mixer stationed next to the oven was observed to have a clean mixing bowl in place but white hardened food splatter and	F 371	F 371 a. Stand up mixer, dishwasher, trash cans, frying pans, streamer, and unit kitchenettes appliances will be cleaned to address the cited concerns. b. Cleaning and observation of sanitation of kitchen equipment and unit kitchenette appliances completed daily. c. Sanitation policy reviewed and remains current relating to kitchen sanitation. All staff will be educated on daily cleaning of kitchen equipment and unit kitchenette appliance daily. Will educated on deep cleaning on a weekly/ monthly basis as scheduled. d. DDS or designee will complete weekly audits of staff cleaning assignments and schedules, and audit all kitchen	2/23/16

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F 371	Continued From page 55 heavy buildup of white food debris around the bottom arm, backside and on and around the underside of the mixer. Food would come in contact with the debris. The DD verified the mixer needed to be cleaned, stating "It was used yesterday" after asking one of the staff he then asked one staff to clean it. -The dishwasher was observed to have heavy white flaky porous lime build up all around the dishwasher and on the inside of the clean side. Inside the dishwasher on the clean side was observed a chute/vent that had heavy porous lime build up which flaked off with touch. DD verified stated the dishwasher was de-limed once a week and then after each use the staff cleaned it. -Three 32 gallon Brute trash cans stationed between the steamer and food warmer; between the gas stove and oven and another between the food prep station and the one compartment sink across from the gas stove and oven which was approximately 22 inches were all three observed to be dirty, covered with heavy amounts of food debris and spatters in the entire outside of the cans. -Two large frying pans were observed on the stove and the inside of both had heavy buildup of a black substance on the cooking surface of the pans. DD verified stated they were going to be cleaned. On a follow up tour on 1/12/15, the two frying pans were again observed on the stove still with heavy black buildup on the inside cooking surface and the entire side. ACU kitchenette, the oven below the microwave was observed with heavy black charcoal like stuff inside the oven and on the racks. When asked	F 371	equipment and 1 unit kitchenette weekly. ED or designee to complete weekly audit of 5 bathrooms for toilet in good repair. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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who was responsible for cleaning the oven, DD stated as far as he knew his dietary 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 slowly dripping near the spout and noted to have stagnant 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 there 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.

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.

2 South kitchenette, the resident microwave was observed with brown dried on food spatters in the inside. In addition the resident toaster was observed with heavy buildup deposits of greasy old bread crumbs in the inside of the toaster grates. DD verified stated toasters were

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F 371	Continued From page 57 supposed to be cleaned daily. Acknowledged the heavy bread crumbs buildup. 2 East fridge kitchenette, the resident refrigerator was observed with dried juice spills around the door seal in the inside and at the bottom underneath the crispy drawers a heavy brown dried buildup was noted. In addition, the resident toaster was noted with heavy deposits of bread crumbs in the inside grates DD verified stated would be cleaned. On 1/11/16, at 5:30 p.m. during a follow up kitchen tour, the steamer glass door was observed to have been cleaned however a white build up coating remained in the inside and door. Upon the cook opening the steamer for meal set up the aluminum foil used to cover the stainless steel containers were all observed to have white dried on stains. When asked what the stains were DD and cook both stated was from the steam condensation in the steamer. On 1/13/16, at 9:58 a.m. during a follow up tour the frying pans were observed turned upside down on the stove. DD was requested to turn them over and both were observed still with heavy substance on the cooking surface and the entire sides. DD stated they still needed to be cleaned. Immediately DD had one of the dietary aides clean them. At 10:16 a.m. dietary aide was observed cleaning the frying pans with steel cleaner then was seen use a scrape but was not able to get the black buildup off. DD then was heard ask the dietary aide to throw the frying pan out and stated he had ordered new ones to replace the two. DD acknowledged the findings and policies and the manual for the steamer were requested DD stated he had spoken with the	F 371		

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F 371	Continued From page 58 company representative who had indicated the buildup would also come back. DD and surveyor opened the steamer and DD verified the lime buildup and verified on the bottom of the steamer was a thin film of dust that was collecting. Sanitation Overview policy reviewed 2/12/2015, indicated "It is the policy of the Dining Services department to practice proper sanitation techniques for clean equipment to prevent the outbreak of foodborne illness, and to train Dining Service employees to use these techniques... Food code 4-601.11Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils.* (1) Equipment, food-contact surfaces, and utensils must be clean to sight and touch. (2) The food-contact surfaces of cooking equipment and pans must be kept free of encrusted grease deposits and other soil accumulations. (3) Non-food-contact surfaces of equipment must be kept free of an accumulation of dust, dirt, food residue, and other debris..."	F 371		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper containment of garbage in the outside dumpster to prevent attracting pests and rodents. This had the potential to affect all 175 residents residing at	F 372	F 372 a. The debris on the ground by the dumpster has been removed. b. Observation of the dumpster area completed daily for needed pick up.	2/23/16

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F 372	Continued From page 59 the facility. Findings include: On 1/12/16, at 11:10 a.m. during a tour to the facility main garbage dumpster the area was observed littered with slices of bread, multiple soiled gloves, used incontinent products all around the main dumpster and underneath the main dumpster. On 1/13/16, on a subsequent visit to the area with the director of dietary the area remained the same heavily littered as noted on the previous day. During the tour the district manager and another staff were in the area walked all around the dumpster the district manager verified the area was heavily littered around and underneath and a mattress was lying next to the dumpster. When asked who was responsible for cleaning the area the district manager stated was a group effort. When asked who was responsible for ensuring the area was clean was not really able to answer and stated was going to have the area clean. On 1/14/16, at 11:00 a.m. the director of dietary stated his staff had been trained to ensure all the garbage was disposed of properly and if the staff noticed the area was littered they were supposed to assisting with cleaning the area and make sure there was no garbage lying around. Waste Disposal policy reviewed 2/12/15, indicated "The Dining Service department will hold, transfer and dispose of waste in a manner that does not create a nuisance or breeding place for insects and rodents, or otherwise permit the transmission of disease." The policy directed staff	F 372	c. Waste disposal policy reviewed and remains current. Staff education on proper trash disposal appropriately in the receptacles and not on the ground. d. DDS or designee will complete weekly audit of dumpster area for debris on the ground. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 372	Continued From page 60 to "Keep dumpster and dumpster site areas clean and free of debris."	F 372		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		2/23/16

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F 431	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure narcotic medications were counted appropriately in 1 of 3 units reviewed for medication storage. In addition, the facility failed to ensure expired medications were disposed of in a timely fashion for 1 of 1 resident (R26) who had lorazepam oral solution. Findings include: R26 was admitted to the facility on 12/25/14, with admission diagnoses of acute respiratory failure and major depression. The Physician Orders indicate Lorazepam (antianxiety medication) Intensol solution was ordered 1/6/15, R26 received 1 dose in January 2015, 16 doses in February 2015, zero doses in March 2015, zero doses in April 2015, zero doses in May 2015, zero doses in June 2015, zero doses in July 2015, 2 doses in August 2015, zero doses in September 2015, zero doses in October 2015, zero doses in November 2015, zero doses in December 2015, and was discontinued 1/5/16. However, the Lorazepam Intensol solution remained in the secured medication refrigerator until discovered 1/13/16. The annual Care Area Assessment (CAA) dated 7/9/15, indicated changing cognitive function and depression. The care plan dated 7/22/15, indicated impaired cognitive function and impaired communication. The Minimum Data Set (MDS) dated 9/18/15, indicated R26 was severely cognitively impaired, and was totally dependent on staff for bed mobility, toilet use, and dressing.	F 431	F431 a. R26 medication removed and destroyed per policy b. All narcotic medications will be reviewed for proper labeling and removal from medication storage areas. c. Storage of medication policy reviewed and remains current. All licensed staff will be educated to the Storage of Medication policy. d. DNS or designee will audit 1 unit medication storage area for proper storage and expired medications. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 431	Continued From page 62 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/milliliter (ml) 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 book the record could be found. There were three numbers written on the box, 84, 127, and 35. Page 84 indicated 13 mls should have been in the vial. Both RN-H and RN-G had participated in the morning narcotic count which 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 though RN-G and RN-H had signed the narcotic books as if a full and accurate count had been completed. The Lorazepam Intensol had last been administered on 8/28/15 (more than 4 months prior). On 1/13/15, at 1:19 p.m. the director of nursing service (DNS) arrived on the floor. DNS verified she had just been informed of the key broken off	F 431		

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F 431	Continued From page 63 in the padlock, and that no-one had reported that to her previously. DNS verified the narcotic count was supposed to be a visual count and verification of the medications on the unit, and it had not been completed accurately. DNS stated she did not believe any Lorazepam Intensol had been diverted (and that it was considered a drug of abuse and that was why it had been locked up). On 1/13/15, at 1:38 p.m. DNS located page 5 in another medication cart and narcotic book, which showed the 13 mls, an additional three doses had been administered, last on 8/28/15 (3 months after the medication should have been destroyed) and the new volume total was now 12.25 mls. The Lorazepam Intensol solution should have been destroyed at the end of May 2015, (7 months ago). The DNS stated the medication was supposed to be destroyed and she had just not had time yet. The destroy [request] was dated 12/5/15. The DNS verified the consultant pharmacy service performed periodic medication room inspections and audits for the facility. The delivery label was unable to be read, the medication had first been administered on 2/20/15 at a volume of 22 ml. R26 had moved to five different rooms in the facility, and the documentation of the medication use was unable to be fully provided at that time (the notes indicating where the medication had been transferred were not present). DNS verified the narcotic medication books lacked documentation of what page and what medication cart the medication had been moved to, the narcotic books contained duplicate pages that were not completed.	F 431		

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It was unable to be determined when the key had broken off in the padlock, as the narcotic counts did not include all of the secured medications on the unit.

On 1/14/16, at 12:30 p.m. the consultant pharmacist (CP) stated he had taken over the building in July, so January 2016 would have been an audit of the medication rooms. He was unsure when the previous pharmacist last audited. CP stated he was not aware of the 90 day expiration for the Lorazepam Intensol, and stated if it was a multi-dose vial it should be good until the manufacturer ' s expiration date. If it had been compounded, the expiration would be much sooner. CP stated the plan of correction would be to audit all the fridges quarterly.

According to the package insert from RLI dated 2012, the Lorazepam Intensol should be stored at 36 to 46 degrees Fahrenheit and discarded 90 days after the medication was opened.

The Storage of Medication policy dated 1/6/15, directed:
"Medications and biologicals are stored properly, following manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administration. The medication supply is accessible only to licensed personal, pharmacy personal, or staff members lawfully authorized to administer medications."

1. Medications are kept in controlled environment, and may include medications carts, medication rooms, medication cabinets, or other suitable containers.
2. Non-controlled medication that have been identified by the nursing care center, as having

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F 431	Continued From page 65 the potential for abuse may also be stored with controlled substances. [Lorazepam Intensol solution]. 11. Mediations requiring refrigeration or temperatures between 36-46 degrees Fahrenheit are kept in a refrigerator with a thermometer. 14. "Outdated or contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. 16. "Medication storage conditions are monitored on a regular basis as a random quality assurance ("QA") check. Recommendations are made for corrective action taken as problems are identified."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		2/23/16

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F 441	Continued From page 66 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure equipment and work surfaces were kept clean and sanitary for 1 of 5 units in which 50 residents resided. In addition, the facility to ensure proper handwashing was performed for 2 of 4 residents (R153, R181) who were observed for cares. Findings include: On 1/13/16 at 7:13 a.m. a medication set up and administration was observed for R93, during the set up registered nurse (RN)-K performed hand hygiene, poured a class of room temperature water for R93 and set it on top of the 2 East nursing station desk while she prepared 7 medications, she then picked up the glass of water and added more water to it, then picked up	F 441	F441 a. R93, R153, and R181 were reviewed for infectious diseases related to not following infection control policy. b. Audit of all surfaces used for medication set-up audited for cleanliness. Audit of all medication crushers audited for cleanliness. Residents that require assistance with pericare to be identified at next care conference to ensure proper pericares completed to reduce risk of infection. Audit of all residents to identify those that require wound care. c. All licensed staff to be educated on Cleaning and Disinfection of Resident care items and equipment policy. All staff assisting with pericares to be educated on Perineal Care Procedure. All staff	

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F 441	Continued From page 67 the medication cup and entered R93's room. The top of the nursing station desk had tape debris and black debris was stuck to it. RN-K moved between the medications and the cup of water without additional hand hygiene. On 1/13/16, at 10:00 a.m. licensed practical nurse (LPN)-F verified the Silent Knight Pill crusher had debris in the crushing area, and along the sides of the pill crusher. The debris was white, brown and black and could be scraped off with a fingernail. The pill crushers were on top of the three medication carts, in an area used for medication preparation. LPN-F further verified the top of the nursing station desk had tape debris and black debris was stuck to it. The medication carts were placed in front of the 2 East nursing desks and medications were sometimes dispensed form the desk area. The Cleaning and Disinfection of Resident-Care Items and Equipment policy dated 8/2014, directed: "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. 1. c. Non-Critical items can be decontaminated where they are used. 7. Intermediate and low-level disinfectants for non-critical items include: a. ethyl or isopropyl alcohol; b. Sodium hypochlorite; c. Phenolic germicidal detergents and d. Iodophor germicidal detergents; e. Quaternary ammonium germicidal detergents."	F 441	educated to facility Handwashing/Hand hygiene procedure. d. DNS or designee to complete weekly audit of 1 unit weekly to ensure clean surfaces for medication set-up, 5 residents for proper pericares, and 5 residents receiving wound care for proper handwashing/ hygiene procedures. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 441	Continued From page 68 Incontinence care: R153's quarterly Minimum Data Set (MDS) dated 11/17/15, indicated resident was cognitively intact, required assistance with activities of daily living (ADLs), and was always incontinent of bowel and bladder. During observation of incontinence cares on 1/13/16, from 10:25 a.m. until 10:35 a.m. and registered nurse (RN)-D present for entire 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 with urine. RN-D verified brief 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. NA-D washed R153's peri area from back to front, then removed the soiled gloves and put new gloves on without washing hands. NA-D applied new incontinence brief. NA-D put blue boots on R153's feet and pulled up covers, then removed gloves, straightened room and put new gloves on. NA-D closed the plastic bag with soiled brief and incontinence wipes and took them to the soiled utility room and then NA-D their washed hands.	F 441		

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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.
NA-D pulled R181 out of dining room and took to room. 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. 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. NA-D used an incontinence wipe to wipe the perineum from front to back. NA-E and NA-D rolled R181 to right side. NA-D wiped R181's bottom from back to front. No stool visible on incontinence wipe.
NA-D removed the soiled gloves, put on new gloves without washing hands or using sanitizer. NA-D put R181's pants and blue boots on. NA-D covered resident up. NA-D applied a new pair of gloves without washing hands and washed R181's eyes and face.

During interview on 1/13/16, at 2:55 p.m. NA-D stated, " I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick. "

During interview on 1/14/16, at 9:22 a.m. the director of nursing services expected staff to at

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least use hand sanitizer when staff remove gloves as long as the gloves are not visible soiled. If the gloves are visible soiled 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 soiled with feces, place resident on side and clean perineum and rectal area.
b. Change water and discard soiled linen appropriately.
c. Change gloves.
d. Turn resident on her back
e. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on the 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 on bedpan and pour clean warm water or cleansing solution over the vulva and perineum.
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.

Wound Care
R153's wound care was observed on 1/14/16, at 7:29 a.m. R153 was sitting in wheelchair. The left

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ankle and heel covered with gauze. The bottom of left great toe was purple. Licensed practical nurse (LPN)-B washed hands and put on gloves. LPN-B used a bandage scissors from their pocket to remove the soiled gauze dressing. LPN-B did not clean the scissors prior to use. There was scant amount of drainage or ointment observed on the gauze. LPN-B cleaned R153's left ankle wound with normal saline and gauze. LPN-B removed the soiled gloves and put new gloves without washing hands. LPN-B wiped the area surrounding the wound with a barrier wipe, then reached into dressing supply caddy with the soiled gloved hands and removed an open square of alginate, foam 2 cm by 2 cm dressing and a roll of gauze. LPN-B cut the clean alginate (a natural wound dressing) with the same soiled scissors that cut the soiled gauze dressing. LPN-B applied Santyl (a sterile enzymatic debriding ointment) using a cotton tipped swab, covered with alginate, then applied foam dressing and wrapped with gauze. LPN-B removed R153's sock on right foot and wiped right heel with skin prep sponge. The right heel observed to be intact without redness or open areas. LPN-B placed the soiled scissors back into the pocket without disinfecting the scissors, removed the soiled gloves and washed their hands.

During interview on 1/14/16, at 8:01 a.m. LPN-B stated, "Generally I do not wash hands between glove changes. I am not sure, I did not think I needed to. I did not wipe my scissors off after cutting off the old dressing and before cutting the alginate. I did reach into the dressing supply caddy with my gloves on after I had cleaned the wound."

During interview on 1/14/16, at 9:22 a.m. the DNS

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said staff should have wiped the scissors of with alcohol after being used. DNS said, "I expect staff to change gloves before reaching into a bucket of clean dressing supplies. Gloves should be changed and hands cleaned with sanitizer or soap and water after completing one wound dressing, before doing another treatment or whenever they remove their gloves."

The facility Handwashing/Hand Hygiene procedure revised August 2014, instructed staff to:

" 7. Use an alcohol-based hand rub containing at least 62% [percent] alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:

a. Before and after coming on duty;
b. Before after and direct contact with residents;
c. Before preparing or handling medications;
d. Before performing any non-surgical invasive procedures;
e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites);
f. Before donning sterile gloves;
g. Before handling clean or soiled dressings, gauze pads, etc.;
h. Before moving from a contaminated body site to a clean body site during resident care;
i. After contact with resident's intact skin;
j. After contact with blood or bodily fluids;
k. After handling used dressings, contaminated equipment, etc.;
l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident: and
m. After removing gloves.
n. Before and after entering isolation precaution settings;
o. Before and after eating or handling food;

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F 441	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."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a safe, sanitary, free of urine odors, and homelike environment. This had the potential to affect 132 of 175 residents in the facility. Findings include: 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 noted to need attention: - The carpet in the hallways was worn and had numerous spots throughout and hallways walls had numerous gouges and black marks on the	F 465	F465 a. The carpeting will be serviced to address worn and numerous spots on 2nd floor. The walls on 2nd floor will be repaired for numerous gouges and black marks on wallboard. The gouge in room 116 will be repaired. The gauge on door of room 209 will be repaired. The missing tiles in room 282 will be replaced. The rooms 209b, 211a, 22/223b, 233a, and 378a with identified urine odors will be deep cleaned. b. Preventative maintenance program in place for identification and repair of safe, functional, sanitary, and comfortable environment. The ED or designee is responsible to complete routine environmental rounds to identify needed	2/23/16

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F 465	Continued From page 74 wallboard on 4 of 4 units on second floor. - Room 116A had a large gouge in the wall board behind the bed - Room 209 - the entrance door to the room had a deep gouge with jagged edge - Room 282 missing tile by the bathroom door, and a bathroom had raised area for the toilet had missing tiles on the upper edge, and the floor was dirty The following areas had a urine odor: - 209 B strong urine smell in the bathroom - 211A strong urine odor in room - 222B/223B strong urine odor in room (shared bathroom) - 233A strong urine odor in room - 378 A urine odor in bathroom At the beginning of the tour on 1/14/16, at 10:00 a.m. the director of maintenance clarified that there were no pending projects for the facility after the remodel was done on first floor to be completed in 2/16. The third floor has been completed and the hopes would be to remodel and update the second floor in the future. At the end of the tour the Director of Maintenance agreed with the environmental issues as listed. The Director of Environmental Services gave the writer a copy of the carpet cleaning schedule for 01/16. The carpet was to have Extract cleaning on 1/6/16 2E, 1/13/16, Extract Center Hall, 1/20/16 Extract 2S, and 1/27/16 Extract 2N. Extraction was the process to clean spots in the carpet. All hallways were to be done on Fridays (one unit each Friday).	F 465	repairs and cleaning to ensure safe functional, sanitary and comfortable environment. c. Education provided to staff on identifying needed repairs and odor issues and notification of housekeeping and maintenance for follow up. d. ED or designee to audit weekly 5 resident rooms and 1 unit for safe functional, sanitary and comfortable environment. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		2/23/16

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F 514	Continued From page 75 LE 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain accurate medical records were complete for 10 of 10 residents (R3, R211, R108, R151, R187, R42, R126, R154, R164, R103) reviewed for monthly pharmacist reviews. 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. The medical record (both paper and electronic) review revealed no record of the monthly medication regimen review's from the pharmacist. The Physician's Orders dated 11/23/15, indicated R3 took pain medications, antihypertensive medications and antipsychotic medications.	F 514	F 514 a. R3, R211, R108, R151, R187, R187, R42, R126, R154, R164, and R103 reviewed for complete medical records regarding pharmacy reviews. b. Audit of residents at next care conference for complete medical records regarding pharmacy reviews c. Clinical pharmacist to complete training on ensuring pharmacy reviews are placed in medical records d. DNS or designee to complete weekly audits of 5 residents to ensure pharmacy reviews are in medical record. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 514	Continued From page 76 On 1/14/16, at approximately 1:10 p.m. the director of nursing services (DNS) verified R3's medical record did not contain any medication regimen review's since admission, and would expect the monthly pharmacist reviews to be readily available for review in resident's individual medical record. R211's Admission Record dated printed on 1/14/16, indicated R211 was most recently admitted to the facility on 8/7/15, with diagnoses including schizoaffective disorder, delusional disorder, and anxiety disorder. R211's Physician's Orders dated 10/25/15, indicated took pain medications, antianxiety medications, antipsychotic medications and other medications. The medical record (both paper and electronic) review revealed the last monthly medication regimen review's from the pharmacist was completed on 6/4/15. On 1/14/16, at 8:45 a.m. the DNS reviewed R211's record and confirmed the last pharmacy consultant review was from 6/4/15, and stated she have called the consultant pharmacist for help. On 1/14/16, at 12:30 p.m. the following information appeared in the electronic medical record for R211's missing pharmacy reviews in the electronic chart: - Effective date: 8/31/15, created on 1/14/15; - Effective date: 9/30/15, created on 1/14/15; - Effective date: 10/30/15, created on 1/14/15; - Effective date: 11/30/15, created on 1/14/15;	F 514		

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F 514	Continued From page 77 - Effective date: 12/31/15, created on 1/14/16; R108's admission Minimum Data Set (MDS) dated 11/9/15, included diagnoses of hypertension, anxiety, fibromyalgia, and lung disease. R108's current admission to the facility was 10/4/13. The medical record indicated R108 was taking cyclobenzaprine (a muscle relaxant) for fibromyalgia, Fentanyl patch every 72 hours for chronic pain, fluoxetine for depression, olanzapine (an anti-psychotic) for major depression, gabapentin for neuropathic pain, and Xanax for anxiety. The pharmacist monthly reviews and recommendations for November and December 2015 were not available in the electronic health record (EHR). The facility could not explain why that had occurred. R151's quarterly MDS dated 12/16/15, included the following diagnoses of hypertension, diabetes mellitus, hyperlipidemia, dementia, and psychotic disorder other than schizophrenia. R151 had an admission date of 9/7/12. The pharmacist's last entry into the electronic record of a pharmacy reviews was done on 6/5/15, and there were no further reviews included in the paper record. The medical record indicated resident was taking insulin, antihypertensive medications, antipsychotic and antianxiety medications. On 1/13/16, at approximately 1:00 p.m. the director of nursing services (DNS) was queried about the whereabouts of the monthly pharmacy reviews for R151 after 6/5/15. The DNS indicated	F 514		

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she was going to contact the facility's consultant pharmacist because she could not find any pharmacy reviews 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.
- 10/30/15 review date, created 1/13/16 at 12:27 p.m.
- 11/30/15 review date, created 1/13/16 at 12:28 p.m.
- 12/31/15 review date, created 1/13/16 at 12:29 p.m.

R187's diagnoses included personal history of other venous thrombosis and embolism, essential (primary) hypertension, atrial fibrillation, personal history of pulmonary embolism, long term (current) use of anticoagulants, hypercholesterolemia, iron deficiency anemia, edema, hypomagnesemia, gastro-esophageal reflux disease without esophagitis and generalized anxiety disorder obtained from the electronic medication record dated January 2015.

The medical record (both paper and electronic) review revealed no record of the monthly medication regimen review's from the pharmacist. The Physician's Orders dated 11/23/15, indicated R3 took pain medications, antianxiety, blood thinner, antihypertensive medications antipsychotic, and hypnotic (sleep aide) medications.

On 1/14/16, at 1:30 p.m. while surveyors were interviewing the consultant pharmacist the following information appeared in the electronic

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F 514	Continued From page 79 medical record for R187's missing pharmacy reviews in the electronic chart: - Effective date: 7/31/15, created on 1/14/16 - Effective date: 8/31/15, created on 1/14/16; - Effective date: 9/30/15, 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 disorder, anxiety disorder, dementia, major depressive disorder, hypertension, diabetes mellitus, and psychosis obtained from admission record printed 1/14/16. R42's Physician's Orders dated 1/14/16, indicated R42 took pain medications, antianxiety medications, antipsychotic, an antidepressant, diabetes oral medications including and insulin medications among others. The medical record (both paper and electronic) review revealed no record of the monthly medication regimen review's from the pharmacist. On 1/14/16, at 1:30 p.m. while surveyors were interviewing the consultant pharmacist the following information appeared in the electronic medical record for R187's missing pharmacy reviews in the electronic chart: - Effective date: 7/31/15, created on 1/14/16 - Effective date: 8/31/15, created on 1/14/16; - Effective date: 9/30/15, 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; R126's diagnoses included hypertension, type II	F 514		

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diabetes mellitus, hyperlipidemia, heart failure, chronic kidney disease stage four and chest pain obtained from admission record printed 1/14/16.

R126's Physician's Orders dated 1/11/16, indicated R126 took multiple antihypertensive medications and insulin medications among others.

The medical record (both paper and electronic) review revealed the last monthly medication regimen review's from the pharmacist was completed on 6/3/15.

On 1/14/16, at 1:38 p.m. the consultant pharmacist stated and showed surveyor his documentation from all the past reviews however no documentation was in either the paper or electronic resident medical record to justify the reviews had been done monthly. The consultant pharmacist stated he had not created the documents and did not have explanation how they were all showing up all of a sudden.

R154's diagnoses included major depressive disorder, post-traumatic stress disorder diabetes, vitamin D deficiency, anxiety disorder, chronic pain, acute embolism on thrombosis of deep veins of lower extremity (blood clot in leg), insomnia, hypertension, fibromyalgia (a disorder that causes muscle pain and fatigue), chronic obstructive pulmonary disease obtained from Admission Record dated 1/14/16.

R154 was admitted 9/30/14. There were no consultant pharmacist's Medication Regimen Review in the chart on 1/13/16 recorded by the pharmacist for July 2015, through January 13, 2016.

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R154's Order Summary dated 1/14/16, indicated R154 took pain medications, antianxiety medications, blood thinner medications, and other medications.

On 1/14/16, at 1:30 p.m. review of electronic health record showed Pharmacy Review for R154's missing pharmacy reviews in the electronic chart:
- Effective date: 8/31/15, created on 1/14/15;
- Effective date: 9/30/15, created on 1/14/15;
- Effective date: 10/30/15, created on 1/14/15;
- Effective date: 11/30/15, created on 1/14/15;
- Effective date: 12/31/15, created on 1/14/16;

R164's diagnoses included subdural hemorrhage, major depressive disorder, hypertension, chronic obstructive pulmonary disease obtained from Admission Record dated 1/14/16.

R164's Order Summary dated 1/14/16, indicated R164 took pain medications, and other medications.

R164 was admitted 8/9/14. There were no consultant pharmacist's Medication Regimen Reviews recorded by the pharmacist for July 2015, through December 2015, in R164's chart.

R103's diagnoses included major depressive disorder, dementia, hypertension, and atrial fibrillation obtained from Admission Record dated 1/14/16.

R103 was admitted 4/21/15. There were no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for July 2015, through December 2015, in R103's chart.

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R103's Order Summary dated 1/14/16, indicated R103 took antidepressant medications, blood thinner medications, and other medications.

The medical record (both paper and electronic) review revealed the last monthly medication regimen review's from the pharmacist was completed on 6/4/15.

On 1/14/16, at 12:30 p.m. the consultant pharmacist indicated the monthly medication review information was produced on a pharmacy based system, and he made entries into the facility EHR [electronic health record, Point Click Care (PCC)] he would give the director of nursing (DON) a copy of the list of residents he had seen and the recommendation he had made would be faxed to the appropriate physician from the PCC system. The CP did not know why his entries into the facility EHR was not available within each individual resident ' s medical record. The DON provided a copy of each visit by the consultant pharmacist. Neither was able to explain why the information was not available in the resident ' s medical record until 1/14/16.

On 1/14/16, at 2:00 p.m. the facility's consultant pharmacist was interviewed verified after he completed the pharmacy reviews he would confer with the DNS on any recommendations and would give the DNS the documentation and the completed fax to be sent to the provider. The pharmacist indicated that he would follow up with the DNS on the recommendations and resolution the following month. If the recommendations had not been acted on he would reissue the recommendation and talk to the DNS. The pharmacist indicated he had his my own

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F 514	Continued From page 83	F 514		

computer he used during the reviews and would then go into Point Click Care (PCC) and if he had recommendation/s he would enter the information in PCC and if no recommendation/s he would simply click no recommendations and get out of the record and go on to the next record.

In addition, the pharmacist indicated he would look at the following when reviewing the resident's records:
- Are medications appropriate for the resident(s),
- Vital signs,
- Progress Notes,
- Any adverse effects of the medications the resident was receiving, and
- Review at target behaviors and how long they have been on their medications.

During the interview with the pharmacist, he indicated he did not know what happened to pharmacy reviews in the facility computer system, PCC and verified he had not created the pharmacy reviews at the time they were all showing on the computer as he was sleeping. The resident's medical lacked evidence of the necessary monthly medication reviews.

The facility's Content of the Medical Record policy dated last revised on 6/3/14, indicated "whether in paper or electronic format, the Resident Medical Record shall contain at least the following information", including "Consultant Pharmacist Notes/Recommendations."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/12/2016**

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**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on January 12, 2016. At the time of this survey, Golden Livingcenter St. Louis Park was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us, Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter St. Louis Park is a 3-story building with no basement. The building was constructed at 2 different times The original building was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a two- story addition was constructed to the East Wing and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 208 beds and had a census of 178 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		2/23/16

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K 054 SS=F	Continued From page 2 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 178 residents. Findings include: On facility tour between 9:00 AM and 3:00 PM on 1/12/2016, a review of the facility's available fire alarm test documentation revealed that the facility failed to conducted the required sensitivity test of each smoke detector, the last smoke detector sensitivity test was conducted in 2013. This deficient practice was verified by the Maintenance Supervisor.	K 054	a. Facility has arranged for required sensitivity testing of each smoke detector. b. Facility has service agreements for completing required testing of fire alarm system. c. Requirements for sensitivity testing has been reviewed by Maintenance. d. ED or designee will complete quarterly audit for required sensitivity testing. Audit results will be reviewed at QAPI meeting and frequency of audits adjusted according to results.	

MDH
Minnesota Department of Health

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,

"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00943	A. BUILDING: _____ B. WING _____	01/14/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On January 11th,12th,13th, and 14th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. At the time of the standard survey completed on January 14,2016, an investigation of complaint number H5148154 was conducted and found to be unsubstantiated.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan for 1 of 2 residents (R187) who used a blood thinner and reviewed for unnecessary medications. Findings include: On 1/14/16, at 12:20 p.m. when approached and asked about her medications, R187 stated she knew most of her medications. R187 stated she did and told surveyor she had received the injections for about six years and had started	2 560	corrected	2/23/16

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2 560	Continued From page 3 when she was pregnant at the time. R187 stated she was aware of the side effect from using the Lovenox (used to prevent deep vein thrombosis (DVT) which can lead to blood clots) such as bruising and stated her abdomen was much bruised. R187 stated the staff did all the administration and her husband did help her in the past. Review of R187's December 2015 to 1/14/16, treatment and medication administration records did not indicate anticoagulant side effect monitoring including risk for bleeding and bruising. Review of the Nurses notes dated 12/20/15 to 1/14/16, revealed no bruises had not been addressed even though resident was able to verbalize how she had sustained them. R187's diagnoses included personal history of other venous thrombosis and embolism, essential (primary) hypertension, atrial fibrillation, personal history of pulmonary embolism and long term (current) use of anticoagulants obtained from the Electronic Medication Record dated January 2015. Review of the care plan dated 4/23/15, revealed R187 had "Altered skin integrity non pressure related..." however, did not indicate R187 had the potential for bruising related to anticoagulation therapy identified/addressed in the care plan. The Physician Order dated 10/5/15, indicated R187 had an order for Enoxaparin Sodium (Lovenox) solution milligram/milliliter (mg/ml) 100 mg subqutaneously every 12 hours for thromboembolism prevention.	2 560		

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2 560	Continued From page 4 On 1/14/16, at 12:56 p.m. registered nurse (RN)-C stated usually for any resident who was on a blood thinner such as Coumadin or Lovenox the facility had a standard order put in the electronic medication administration record (EMAR) for the nurses to check every shift. RN-C stated usually there was no care plan for it as the staff were already signing off on the side effects in the EMAR. -At 1:00 p.m. RN-B approached stated "It should be" when asked if a care plan was supposed to be developed when someone was on a blood thinner such as R187. RN-B verified the current care plan and even previous cares plans had not addressed R187 potential for bruising and bleeding. On 1/14/16, at 2:00 p.m. the director of nursing services (DNS) stated a care plan was supposed to have been developed for R187 if resident had been identified as using a blood thinner. Anticoagulant Therapy Guideline last reviewed 01/22/2015, directed staff: · Complete an Immediate Plan of Care (IPOC) within 24 hours following initiation of anticoagulation therapy. · Integrate interventions from IPOC into comprehensive plan of care upon completion of interdisciplinary care plan meeting ..." In addition, the policy indicated for the facility to demonstrate satisfactory monitoring/compliance an immediate plan of care was to be individualized and a physical observation showed plan was implemented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff to the development of a comprehensive care plan, then audit to ensure	2 560		

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2 560	Continued From page 5 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 3 of 5 residents (R13, R153, R181) reviewed for bowel and bladder incontinence and for 2 of 3 residents (R153, R181) for reviewed repositioning. Findings include: Toileting: R13's room was observed on 1/14/16, at 7:16 a.m. Upon entering R13's room strong urine smell was noted but R13 was not in the room at the time. At 7:17 a.m. when asked what time resident had been assisted to get ready for the day nursing assistant (NA)-B stated he had assisted the resident as R13 had been up at 6:45 a.m. During continuous observation to 10:05 a.m. R13 was not toileted or offered to be checked and change for three hours and 15 minutes. On 1/14/15, at 10:15 a.m. NA-B acknowledged	2 565	corrected	2/23/16

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2 565	Continued From page 6 resident had not been toileted timely and was over one hour and 15 minutes from when resident had last been checked and changed. NA-B stated "We are under staffed and some of the residents in the unit need two staff with transfers because they use the transfer machine and some are combative and if two aides go into the room for half hour they is no way I can tell another resident in the middle of cares I have to go now. Someone can point a finger at me but we are under staffed and for 27 residents for two aides with heavy cares it's impossible. I have not even take a 15 minute break and in 20 minutes will be lunch here coming and I am shaking." -At 10:26 a.m. LPN stated NA's were supposed to follow the plan of care and were supposed to toilet the resident timely. LPN-B further stated she would have expected NA-B to report to her he was running late to toilet and resident had refused and she would have attempted to re-approach resident as she did. R13's urinary Incontinence indwelling catheter Care Area Assessment (CAA) dated 10/14/15, identified resident was incontinent of bowel and bladder, was at risk for urine body odor, urinary tract infections and skin breakdown. R13's care plan dated 11/13/14, identified resident had a functional incontinence of bladder and bowel. Care plan directed staff to provide assistance of one to toilet. Use briefs/pads for incontinence protection and to toilet resident every two hours 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.	2 565		

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2 565	Continued From page 7 R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. and R153 was not toileted for at least three hours. At 10:09 a.m. 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, "No." At 10:19 a.m. NA-B brought R153 to room after asking permission. At 10:25 a.m. NA-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. There was a strong odor of urine present when R153 was lying in bed. RN-D was present and verified the 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 with urine and RN-D verified the brief was saturated. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. NA-D washed R153's peri area from back to front, then applied new incontinence brief. The Alteration in Elimination of Bowel and Bladder, Incontinence of bowel and bladder care plan dated 6/29/15, instructed staff to check and change resident every two hours and as needed. Care plan dated 11/18/15, indicated R153 had a physical functioning deficit related to self-care impairment, and mobility impairment. Care plan goals were that R153 would be clean, dry, and odor free. Care plan instructed staff that R153 required extensive assist of one for dressing, personal hygiene, bathing, and toileting. It also indicated R153 had a history of refusing some ADL assistance depending on mood. The undated nursing assistant assignment sheet for R153 instructed staff that R153 was	2 565		

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	00943	A. BUILDING: _____ B. WING _____	01/14/2016

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2 565	Continued From page 8 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. Bladder assessment dated 12/22/15, indicated R181 had functional urinary incontinence and was not appropriate for toileting or retraining program because of dementia and immobility. The care plan dated 1/12/16, indicated resident was functionally incontinent of bowel and bladder. It instructed staff to check and change R181 every two and as needed. Undated nursing assistant assignment sheet for R181 instructed staff that R181 was incontinent and was to be checked and change every two hours and as needed. During interview on 1/13/16, at 9:49 a.m. NA-B said, "[R153] was our third resident to get up. We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities and had not been asked or refused that morning. [R181]	2 565		

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2 565	Continued From page 9 was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11:00 a.m. Then at 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting." - At 9:56 a.m. licensed practical nurse (LPN)-B said R153 was to be repositioned every two hours and check and change every two hours. R153 could also ask to be changed. LPN-B acknowledged R153 had not been toileted in over two hours. LPN-B stated LPN-B would have someone take care of it right away. R181 was to be checked and change every two hours. - At 10:11 a.m. NA-E stated we got R153 up around 6:30 a.m. - At 10:13 a.m. registered nurse (RN)-D stated R153 was to be repositioned every two hours and offered to be changed every two hours. - At 2:47 p.m. nursing assistant (NA)-B stated was working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." NA-D said, "I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick." - At 9:22 a.m. the director of nursing services (DNS) said, "I expect the staff to follow our policy regarding incontinence care I expect them to check and change residents in accordance to their care plans." R153 and R181 was not provided incontinent cares according to the plan of care.	2 565		

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2 565	Continued From page 10 Repositioning: 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, 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 9:49 a.m. R153 sitting in activity room. - At 10:09 a.m. 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, "No." - At 10:19 a.m. NA-B brought R153 to room after asking permission. - At 10:25 a.m. 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 was present and verified the coccyx was red and not blanchable. The Pressure Ulcer CAA dated 6/26/15, indicated "CAA triggered for pressure r/t Hx [history of] of CVA [stroke] with weakness, res. is incontinent, requires staff assistance with bed mobility/cares, see MDS ADL/continence coding. Res. [resident] is at risk for pressure, infection, pain and overall decline." The care plan revised 1/12/16, indicated pressure ulcer present to right heel - suspected deep tissue injury. Ulceration to left lateral malleolus. Interventions included heel boots to be worn while resident was in bed and had specialized boots that are stationary in wheelchair, provided by	2 565		

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2 565	Continued From page 11 therapy, float heels while in bed, offload every two hours. R181 was observed on 1/13/16, from 7:00 a.m. until 8:55 a.m. for repositioning. - At 7:00 a.m. R181 was sitting in dining room. Mechanical lift sling under R181. - At 7:45 a.m. NA-B sat down and talked with R181 - At 7:56 a.m. breakfast was delivered to R181 and NA-B started to feed R181. - At 8:10 a.m. speech therapy working with R181 at the dining room table. - At 8:46 a.m. NA-D pulled R181 out of dining room and took to room. NA-D and NA-E transferred R181 from wheelchair to bed using a mechanical lift. The peri area was observed to be red from front to approximately four centimeter cm above the rectum. When NA-D touched skin, area blanched. NA-D put R181's pants and blue boots on. Urinary incontinence CAA dated 12/24/15, indicated "CAA triggered dr/t (sic) urine incontinence. Res is at risk for skin break down, UTI. Proceed to care plan to ensure staff aware and provide care PRN [as needed]. Update MD [medical doctor] NP [nurse practitioner] PRN." The plan off care initiated on 1/6/16, directed staff to turn and reposition R181 every two hours. During interview on 1/13/16, at 9:49 a.m. NA-B said R153 was the third resident to get up. "We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities, has not been asked or refused this morning. [R181] was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11	2 565		

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2 565	Continued From page 12 a.m. Then 1 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting." - At 9:56 a.m. LPN-B said (R153) was to be repositioned every two hours. LPN-B acknowledged R181 was to be repositioned every two hours. - At 10:11 a.m. NA-E stated, "We got [R153] up around 6:30 a.m." - At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures." RN-D stated R181 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures." - At 2:47 p.m. NA-B stated they were working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said, "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service staff regarding how to correctly implement a resident plan of care, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 625	Continued From page 13	2 625		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care;	2 625		2/23/16

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2 625	Continued From page 14 N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain accurate medical records were complete for 10 of 10 residents (R3, R211, R108, R151, R187, R42, R126, R154, R164, R103) reviewed for monthly pharmacist reviews. 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. The medical record (both paper and electronic) review revealed no record of the monthly medication regimen review's from the pharmacist. The Physician's Orders dated 11/23/15, indicated R3 took pain medications, antihypertensive medications and antipsychotic medications. On 1/14/16, at approximately 1:10 p.m. the director of nursing services (DNS) verified R3's medical record did not contain any medication regimen review's since admission, and would expect the monthly pharmacist reviews to be readily available for review in resident's individual	2 625	corrected	

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2 625	Continued From page 15 medical record. R211's Admission Record dated printed on 1/14/16, indicated R211 was most recently admitted to the facility on 8/7/15, with diagnoses including schizoaffective disorder, delusional disorder, and anxiety disorder. R211's Physician's Orders dated 10/25/15, indicated took pain medications, antianxiety medications, antipsychotic medications and other medications. The medical record (both paper and electronic) review revealed the last monthly medication regimen review's from the pharmacist was completed on 6/4/15. On 1/14/16, at 8:45 a.m. the DNS reviewed R211's record and confirmed the last pharmacy consultant review was from 6/4/15, and stated she have called the consultant pharmacist for help. On 1/14/16, at 12:30 p.m. the following information appeared in the electronic medical record for R211's missing pharmacy reviews in the electronic chart: - Effective date: 8/31/15, created on 1/14/15; - Effective date: 9/30/15, created on 1/14/15; - Effective date: 10/30/15, created on 1/14/15; - Effective date: 11/30/15, created on 1/14/15; - Effective date: 12/31/15, created on 1/14/16; R108's admission Minimum Data Set (MDS) dated 11/9/15, included diagnoses of hypertension, anxiety, fibromyalgia, and lung disease.	2 625		

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2 625	Continued From page 16 R108's current admission to the facility was 10/4/13. The medical record indicated R108 was taking cyclobenzaprine (a muscle relaxant) for fibromyalgia, Fentanyl patch every 72 hours for chronic pain, fluoxetine for depression, olanzapine (an anti-psychotic) for major depression, gabapentin for neuropathic pain, and Xanax for anxiety. The pharmacist monthly reviews and recommendations for November and December 2015 were not available in the electronic health record (EHR). The facility could not explain why that had occurred. R151's quarterly Minimum Data Set (MDS) dated 12/16/15, included the following diagnoses of hypertension, diabetes mellitus, hyperlipidemia, dementia, and psychotic disorder other than schizophrenia. R151 had an admission date of 9/7/12. The pharmacist ' s last entry into the electronic record of a pharmacy reviews was done on 6/5/15, and there were no further reviews included in the paper record. The medical record indicated resident was taking insulin, antihypertensive medications, antipsychotic and antianxiety medications. On 1/13/16, at approximately 1:00 p.m. the director of nursing services (DNS) was queried about the whereabouts of the monthly pharmacy reviews for R151 after 6/5/15. The DNS indicated she was going to contact the facility's consultant pharmacist because she could not find any pharmacy reviews after 6/5/15.	2 625		

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2 625	Continued From page 17 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. - 10/30/15 review date, created 1/13/16 at 12:27 p.m. - 11/30/15 review date, created 1/13/16 at 12:28 p.m. - 12/31/15 review date, created 1/13/16 at 12:29 p.m. R187's diagnoses included personal history of other venous thrombosis and embolism, essential (primary) hypertension, atrial fibrillation, personal history of pulmonary embolism, long term (current) use of anticoagulants, hypercholesterolemia, iron deficiency anemia, edema, hypomagnesemia, gastro-esophageal reflux disease without esophagitis and generalized anxiety disorder obtained from the electronic medication record dated January 2015. The medical record (both paper and electronic) review revealed no record of the monthly medication regimen review's from the pharmacist. The Physician's Orders dated 11/23/15, indicated R3 took pain medications, antianxiety, blood thinner, antihypertensive medications antipsychotic, and hypnotic (sleep aide) medications. On 1/14/16, at 1:30 p.m. while surveyors were interviewing the consultant pharmacist the following information appeared in the electronic medical record for R187's missing pharmacy reviews in the electronic chart: - Effective date: 7/31/15, created on 1/14/16	2 625		

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2 625	Continued From page 18 - Effective date: 8/31/15, created on 1/14/16; - Effective date: 9/30/15, 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 disorder, anxiety disorder, dementia, major depressive disorder, hypertension, diabetes mellitus, and psychosis obtained from admission record printed 1/14/16. R42's Physician's Orders dated 1/14/16, indicated R42 took pain medications, antianxiety medications, antipsychotic, an antidepressant, diabetes oral medications including and insulin medications among others. The medical record (both paper and electronic) review revealed no record of the monthly medication regimen review's from the pharmacist. On 1/14/16, at 1:30 p.m. while surveyors were interviewing the consultant pharmacist the following information appeared in the electronic medical record for R187's missing pharmacy reviews in the electronic chart: - Effective date: 7/31/15, created on 1/14/16 - Effective date: 8/31/15, created on 1/14/16; - Effective date: 9/30/15, 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; R126's diagnoses included hypertension, type II diabetes mellitus, hyperlipidemia, heart failure, chronic kidney disease stage four and chest pain obtained from admission record printed 1/14/16.	2 625		

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2 625	Continued From page 19 R126's Physician's Orders dated 1/11/16, indicated R126 took multiple antihypertensive medications and insulin medications among others. The medical record (both paper and electronic) review revealed the last monthly medication regimen review's from the pharmacist was completed on 6/3/15. On 1/14/16, at 1:38 p.m. the consultant pharmacist stated and showed surveyor his documentation from all the past reviews however no documentation was in either the paper or electronic resident medical record to justify the reviews had been done monthly. The consultant pharmacist stated he had not created the documents and did not have explanation how they were all showing up all of a sudden. R154's diagnoses included major depressive disorder, post-traumatic stress disorder diabetes, vitamin D deficiency, anxiety disorder, chronic pain, acute embolism on thrombosis of deep veins of lower extremity (blood clot in leg), insomnia, hypertension, fibromyalgia (a disorder that causes muscle pain and fatigue), chronic obstructive pulmonary disease obtained from Admission Record dated 1/14/16. R154 was admitted 9/30/14. There were no consultant pharmacist's Medication Regimen Review in the chart on 1/13/16 recorded by the pharmacist for July 2015, through January 13, 2016. R154's Order Summary dated 1/14/16, indicated R154 took pain medications, antianxiety medications, blood thinner medications, and other	2 625		

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2 625	Continued From page 20 medications. On 1/14/16, at 1:30 p.m. review of electronic health record showed Pharmacy Review for R154's missing pharmacy reviews in the electronic chart: - Effective date: 8/31/15, created on 1/14/15; - Effective date: 9/30/15, created on 1/14/15; - Effective date: 10/30/15, created on 1/14/15; - Effective date: 11/30/15, created on 1/14/15; - Effective date: 12/31/15, created on 1/14/16; R164's diagnoses included subdural hemorrhage, major depressive disorder, hypertension, chronic obstructive pulmonary disease obtained from Admission Record dated 1/14/16. R164's Order Summary dated 1/14/16, indicated R164 took pain medications, and other medications. R164 was admitted 8/9/14. There were no consultant pharmacist's Medication Regimen Reviews recorded by the pharmacist for July 2015, through December 2015, in R164's chart. R103's diagnoses included major depressive disorder, dementia, hypertension, and atrial fibrillation obtained from Admission Record dated 1/14/16. R103 was admitted 4/21/15. There were no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for July 2015, through December 2015, in R103's chart. R103's Order Summary dated 1/14/16, indicated R103 took antidepressant medications, blood thinner medications, and other medications.	2 625		

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2 625	Continued From page 21 The medical record (both paper and electronic) review revealed the last monthly medication regimen review's from the pharmacist was completed on 6/4/15. On 1/14/16, at 12:30 p.m. the consultant pharmacist indicated the monthly medication review information was produced on a pharmacy based system, and he made entries into the facility EHR [electronic health record, Point Click Care (PCC)] he would give the director of nursing (DON) a copy of the list of residents he had seen and the recommendation he had made would be faxed to the appropriate physician from the PCC system. The CP did not know why his entries into the facility EHR was not available within each individual resident ' s medical record. The DON provided a copy of each visit by the consultant pharmacist. Neither was able to explain why the information was not available in the resident ' s medical record until 1/14/16. On 1/14/16, at 2:00 p.m. the facility's consultant pharmacist was interviewed verified after he completed the pharmacy reviews he would confer with the DNS on any recommendations and would give the DNS the documentation and the completed fax to be sent to the provider. The pharmacist indicated that he would follow up with the DNS on the recommendations and resolution the following month. If the recommendations had not been acted on he would reissue the recommendation and talk to the DNS. The pharmacist indicated he had his my own computer he used during the reviews and would then go into Point Click Care (PCC) and if he had recommendation/s he would enter the information in PCC and if no recommendation/s he would simply click no recommendations and get out of the record and go on to the next record.	2 625		

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2 625	Continued From page 22 In addition, the pharmacist indicated he would look at the following when reviewing the resident's records: - Are medications appropriate for the resident(s), - Vital signs, - Progress Notes, - Any adverse effects of the medications the resident was receiving, and - Review at target behaviors and how long they have been on their medications. During the interview with the pharmacist, he indicated he did not know what happened to pharmacy reviews in the facility computer system, PCC and verified he had not created the pharmacy reviews at the time they were all showing on the computer as he was sleeping. The resident's medical lacked evidence of the necessary monthly medication reviews. The facility's Content of the Medical Record policy dated last revised on 6/3/14, indicated "whether in paper or electronic format, the Resident Medical Record shall contain at least the following information", including "Consultant Pharmacist Notes/Recommendations." The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring that pharmacist recommendations are documented correctly in the medical record. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure pharmacist reccomndations are readily made available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		

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2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 1 resident (R181) reviewed for dignified care and services, the facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 4 resident (R153) who was incontinent of stool, for 2 of 3 residents (R153, R181) reviewed for potential skin breakdown, for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence. In 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) who were interviewed and expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 175 residents who currently resided in the facility. Findings include: Assessed resident needs not met: > Refer to F241: The facility failed to provide	2 800	corrected	2/23/16

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2 800	Continued From page 24 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) 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. > Refer to F315: The facility failed to provide timely assistance with incontinence care for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence. Resident Interview: R166's quarterly Minimum Data Set (MDS) dated 10/7/15, indicated R166 had intact cognition required extensive physical assistance of one staff with personal hygiene and was independent with toileting, dressing, transfers and bed mobility. In addition, the MDS indicated R166 used both a walker and wheelchair for mobility. On 1/11/16, at 4:29 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "Sometimes the staff ignore you and when I have my button for a long time and sometimes I	2 800		

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2 800	Continued From page 25 just need ice." R183's quarterly MDS dated 10/8/15, indicated cognition was moderately impaired and was independent with all activities of daily living (ADLs). On 1/11/16, at 4:52 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "They are people here who have to wait for a long time and this people are calling for a long time." R125's quarterly MDS dated 11/10/15, indicated cognition was intact and required extensive physical assistance of one to two staff with bed mobility, dressing, toileting and personal hygiene. In addition, the MDS indicated R125 used a wheelchair for mobility. On 1/11/16, at 4:05 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "Takes a little before they come an hour and can be even longer." R187's quarterly MDS dated 12/10/15, indicated cognition was intact and R187 required limited to extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R187 used a wheelchair for mobility and had no behaviors.	2 800		

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2 800	Continued From page 26 On 1/11/16, at 2:59 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated, "I have had plenty of accidents right now from waiting for staff to assist me. They have me in a pad and I don ' t like them. Before my fall, I was able to transfer myself not anymore. I have had to call them with my phone I don ' t hesitate. This morning we had one aide for 30 residents this floor." R192's quarterly MDS dated 11/7/15, indicated cognition was intact and required limited to extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R192 used a wheelchair for mobility and had a functional limitation in range of motion on one side of the lower extremity. On 1/11/15, at 4:11 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated staff would go out of the room after answering the call light and would indicate were going to get assistance. R49's quarterly MDS dated 11/4/15, indicated cognition was moderately impaired and required total to extensive physical assistance of two staff with dressing, toileting, transfers and personal hygiene. In addition, the MDS indicated R49 used a wheelchair for mobility and had no behaviors. On 1/12/16, at 9:10 a.m. during interview when asked if he felt there was enough staff available	2 800		

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2 800	Continued From page 27 to make sure you get the care and assistance you need without having to wait a long time resident stated, "Weekends, especially Sunday there is hardly any staff around. I suppose it's my fault for not planning well." R3's quarterly minimum data set (MDS) indicated R3 was cognitively intact with a diagnosis of schizophrenia. During interview on 1/13/16, at 12:30 p.m. R3 said they are understaffed here. "It is not a problem for me but it is for other residents especially in the evening or the nights. Staffing concerns are shared at resident council regularly. They told us that was why they could not open the new sub acute unit." Staff interviews: On 1/13/16, at 6:14 a.m. licensed practical nurse (LPN)-C stated the shift was usually sometimes short staff and had to help the aides with turning and repositioning residents who required two assistance. LPN-C indicated at times it was not possible to finish the workload and had to ask for a pink slip to finish the work. LPN-C further stated most of the times had to prioritize the resident needs and had to have residents wait before their needs were attended to which would be a while. On 1/13/16, at 6:21 a.m. registered nurse (RN)-F stated the night shift was not short staff but on other shifts when a trained medication aide (TMA) was supposed to work with a nurse most times would not be staffed and the nurse had to do all the work. When asked if the workload was manageable RN-F stated "You can only do the best you can and would ask the supervisor to	2 800		

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2 800	Continued From page 28 help and if they don't you do the best." RN-F stated on shifts like those breaks were not taken and resident needs 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." On 1/13/16, at 7:58 a.m. LPN-D stated usually there were two nurses for 2 South and 2 North and the units shared a TMA who went between the units to pass medications. LPN-D stated at times if the unit was short of an NA the TMA was bumped off the cart and instead at times this position was covered by a nurse which LPN-D thought was good as the nurse was able to do a lot more including insulin's. LPN-D stated the units were staffed with two nursing assistants (NAs) and did not think 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. On 1/13/16, at 7:31 a.m. to 9:10 a.m. during continuous observations at the 2 South nursing station, several residents were overheard walk up to the LPN-E asked for their morning medications. LPN-E was heard re-direct residents and told them she would bring it to them. At 9:18 a.m. when asked if she was running behind with	2 800		

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2 800	Continued From page 29 the medication pass LPN-E stated as she smiled "I have not even started." LPN-E was observed on multiple times being interrupted into resident rooms for assist with cares and was leaving the unit to go get pain medications out of the machine located in 2 East which took time away from passing medications timely and the screen windows for some of the residents had even turned red which indicated the medication pass time window had exceeded. On 1/13/16, at 9:28 a.m. when asked about sufficient nursing NA-F stated it was difficult to get the workload done. When asked if the resident needs were met timely such as repositioning, turning and toileting needs NA-F stated "We try but sometimes we just can't get to it because it is so heavy and the resident ' s requests can be a lot and not being able to get to them timely." -At 9:35 a.m. the director of nursing services (DNS) was apprised of observations of LPN-E working but was not able to get the medication pass going. DNS stated the facility was in the process of hiring a TMA for 2 South and 2 North. DNS verified looking into the computer screen window LPN-E was on the screen for medication administration record red. -At 9:48 a.m. R46 approached LPN-E and was overheard indicate to LPN-E she was still waiting for her medications. LPN-E acknowledged resident request. -At 9:50 a.m. after concern was brought to the DNS attention, three nurses were observed to assist LPN-E with the unit medication pass and all the computer screen windows were noted to be red with all the medications that were being in an untimely fashion. - At 2:47 p.m. NA-B stated was working a double. NA-B stated, "right now we are short staffed."	2 800		

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2 800	Continued From page 30 When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You can not always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D stated "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." On 1/14/16, at 10:15 a.m. NA-B stated "We are under staffed and some of the residents in the unit need two staff with transfers because they use the transfer machine and some are combative and if two aides go into the room for half hour they is no way I can tell another resident in the middle of cares I have to go now. Someone can point a finger at me but we are under staffed and for 27 residents for two aides with heavy cares it's impossible. I have not even taken a 15 minute break and in 20 minutes will be lunch here coming and am shaking." The facility staffing pattern was based on units as follows: Unit 1 North- Census 23 -Day shift- one nurse manager (NM), two RN, and three NA's -Evening shift- had one nursing supervisor (SUP) for the building, two 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). Unit 2 North-Census 29 & 2 South-Census 30 -Day shift one nurse assigned to 2 North and one nurse assigned to 2 South, one TMA who went between 2 North and 2 South to assist with	2 800		

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2 800	Continued From page 31	2 800		

medication administration, three + two and a half (total of 5 1/2) NA's with some varying hours to cover people getting up and dressed, or ready for bed.
- Evening shift- one nurse assigned to 2 North and one nurse assigned to 2 South, one TMA who went between 2 North and 2 South to assist with medication administration, two and a half + two and a half (total of 5) CNA's with varying hours.
-Night shift- one nurse and one NA for each side.
Unit 2 East- Census 50
-Day shift one NM, three nurses, and six NA's
-Evening shift two nurses and one TMA or three nurses, and five NA's
-Night shift two nurses and two NA
Unit ACU Census 27 and AACU Census 25 (staff as one unit).
-Day shift one NM and one nurse on each side 5 NA's with varying hours
-Evening shift one nurse on each side and five NA
-Night shift one nurse between the sides and two NA's.
Weekend supervisor day shift, rotates between the nurse managers, the evening and night supervisors are hired positions (one currently vacant).

The daily staffing sheets were reviewed and were nearly unreadable, from the changes and the staff hand written in and show a progressive decline in planned staff (typewritten in), vs hand written in staff. Example, on Wednesday 1/6/16, for the facility, 17 nurses were typewritten onto the schedule and 15 were hand written 46% were added after the schedule was planned; NA's on 1/6/16, 24 were typewritten in and 26 were handwritten in. 52% were added after the schedule was planned. One nursing supervisor

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 32 did a double from days to evenings and two LPN's did doubles from days to evenings. The facility DNS and staffer felt the facility was able to cover all shifts budgeted hours by changing the composition of the staff when needed (if short a nurse increase TMA or NA hours, if short a NA and unable to fill than increase nurse hours). The DNS had acted as the evening supervisors twice in the past year, with a census over 170. The DNS stated "staff work really well and shifts are getting filled, it's not easy and we are not at optimal staffing every day." The DNS revealed that 60% of RN/LPN FTE (full time equivalent = 80 hour per pay period) was open positions due to the hiring occurring at a nearby hospital. The NA open FTE was 58.1%, staff were leaving and citing more pay down the street. The facility was in the process of reviewing the wage scale, and benchmarking with the community. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review current and ongoing staffing patterns to evaluate if addition or relocation of staff is needed to ensure all resident cares needs are met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director	2 900		2/23/16

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	00943	A. BUILDING: _____ B. WING _____	01/14/2016

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2 900	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 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, 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 9:49 a.m. R153 sitting in activity 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, "No."	2 900	corrected	

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2 900	Continued From page 34 - At 10:19 a.m. NA-B brought R153 to room after asking permission. - At 10:25 a.m. 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. Registered nurse (RN)-D was present and verified the coccyx was red and not blanchable. The Pressure Ulcer Care Area Assessment (CAA) dated 6/26/15, indicated "CAA triggered for pressure r/t [related to] Hx [history of] of CVA [stroke] with weakness, res. is incontinent, requires staff assistance with bed mobility/cares, see MDS [Minimum Data Set] ADL[activities of daily living]/continence coding. Res. [resident] is at risk for pressure, infection, pain and overall decline." The Comprehensive Skin Assessment dated 9/22/15,indicated R153 had a current ulcer right and left heels and a history of pressure ulcer on buttock. Intervention indicated reposition every two hours. R153's quarterly MDS dated 11/17/15, indicated resident was cognitively intact, required assistance with ADLs, and was always incontinent of bowel and bladder. R153's diagnoses listed quarterly MDS included stroke, psychosis and mood disorder. The care plan revised 1/12/16, indicated pressure ulcer present to right heel - suspected deep tissue injury. Ulceration to left lateral malleolus. Interventions included heel boots to be worn while resident was in bed and had specialized boots that are stationary in wheelchair, provided by therapy, float heels while in bed, and offload	2 900		

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2 900	Continued From page 35 every two hours. The undated Nursing Assistant Assignment Sheet for R153 instructed staff that R153 turning and repositioning schedule was R153 required assist of two with off loading and transfers using a large sling and mechanical lift. R153 was to have boots on feet while in be and in wheel chair. R181 was observed on 1/13/16, from 7:00 a.m. until 8:55 a.m. for repositioning. - At 7:00 a.m. R181 was sitting in dining room. Mechanical lift sling under R181. - At 7:45 a.m. NA-B sat down and talked with R181 - At 7:56 a.m. breakfast was delivered to R181 and NA-B started to feed R181. - At 8:10 a.m. speech therapy working with R181 at the dining room table. - At 8:46 a.m. NA-D pulled R181 out of dining room and took to room. NA-D and NA-E transferred R181 from wheelchair to bed using a mechanical lift. The peri area was observed to be red from front to approximately four centimeter cm above the rectum. When NA-D touched skin, area blanched. NA-D put R181's pants and blue boots on. Urinary Incontinence CAA dated 12/24/15, indicated "CAA triggered dr/t [sic] urine incontinence. Res is at risk for skin break down, UTI [urinary tract infection]. Proceed to care plan to ensure staff aware and provide care PRN [as needed]. Update MD [medical doctor] NP [nurse practitioner] PRN." The plan off care initiated on 1/6/16, directed staff to turn and reposition R181 every two hours.	2 900		

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2 900	Continued From page 36 During interview on 1/13/16, at 9:49 a.m. NA-B said R153 was the third resident to get up. "We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities, has not been asked or refused this morning. [R181] was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11 a.m. Then 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting." - At 9:56 a.m. LPN-B said (R153) was to be repositioned every two hours. LPN-B acknowledged R181 was to be repositioned every two hours. - At 10:11 a.m. NA-E stated, "We got [R153] up around 6:30 a.m." - At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures." RN-D stated R181 was to be repositioned every two hours. "If it does not occur there would be skin issues, skin breakdown potential deep vein thrombosis (clots) or contractures." - At 2:47 p.m. NA-B stated they were working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said, "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." The undated Golden Clinical Services Skin integrity Guideline instructed staff to "reposition	2 900		

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2 900	Continued From page 37 every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care" and "Care plan is to be implemented, evaluated and revised based on the needs of the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of a care plan to ensure appropriate treatment of pressure ulcers, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced	2 910		2/23/16

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2 910	Continued From page 38 by: Based on observation, interview, and document review, the facility failed to provide timely assistance with activities of daily living for 1 of 3 resident (R153) who was incontinent of stool. In addition, the facility failed to provide timely assistance with incontinence care for 3 of 4 residents (R13, R153, R181) reviewed for urinary incontinence. Findings include: Bowel: R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. and R153 was not toileted for at least three hours. At 10:09 a.m. 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, "No." At 10:19 a.m. NA-B brought R153 to room after asking permission. At 10:25 a.m. NA-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. There was a strong odor of urine present when R153 was lying in bed. RN-D was present and verified the 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 with urine and RN-D verified the brief was saturated. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. NA-D washed R153's peri area from back to front, then applied new incontinence brief. Bladder assessment dated 6/15/15 and reviewed 11/17/15, indicated resident was not appropriate for bowel and bladder retraining program due to diagnosis of dementia, psychosis and unspecified cerebrovascular disease. Staff was to toilet R153	2 910	corrected	

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2 910	Continued From page 39 every 2 hours and as needed. The Urinary Incontinence Care area assessment (CAA) dated 6/26/15, indicated, "CAA triggered for incontinence r/t[related to] res. [resident] is incontinent of bowel and bladder, see MDs (sic) ADL/continence coding. Res. is at risk for UTI, Skin CAA triggered for incontinence r/t res. is at risk for UTI, skin breakdown, unmet hygiene needs." The Alteration in Elimination of Bowel and Bladder, Incontinence of bowel and bladder care plan dated 6/29/15, instructed staff to check and change resident every two hours and as needed. Care plan dated 11/18/15, indicated R153 had a physical functioning deficit related to self-care impairment, and mobility impairment. Care plan goals were that R153 would be clean, dry, and odor free. Care plan instructed staff that R153 required extensive assist of one for dressing, personal hygiene, bathing, and toileting. It also indicated R153 had a history of refusing some ADL assistance depending on mood. The undated nursing assistant assignment sheet for R153 instructed staff that R153 was incontinent of bowel and bladder and was to be checked and change every two hours. During interview on 1/13/16, at 9:49 a.m. NA-B said, "[R153] was our third resident to get up. We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities and had not been asked or refused that morning. - At 9:56 a.m. licensed practical nurse (LPN)-B said R153 was to be repositioned every two hours and check and change every two hours. R153 could also ask to be changed. LPN-B	2 910		

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2 910	Continued From page 40 acknowledged R153 had not been toileted in over two hours. LPN-B stated LPN-B would have someone take care of it right away. - At 10:11 a.m. NA-E stated we got R153 up around 6:30 a.m. - At 10:13 a.m. registered nurse (RN)-D stated R153 was to be repositioned every two hours and offered to be changed every two hours. - At 2:47 p.m. nursing assistant (NA)-B stated was working a double. NA-B stated, "right now we are short staffed." When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said, "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." NA-D said, "I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick." - At 9:22 a.m. the director of nursing services (DNS) said, "I expect the staff to follow our policy regarding incontinence care I expect them to check and change residents in accordance to their care plans." R153 was not provided incontinent cares according to the plan of care. A bowel assessment requested but not provided. Facility procedure Incontinence Management/Bladder Function Guideline effective date 1/19/15, Indicated the purpose of a bladder management program is to: ..."Manage urinary incontinence, restore or maintain as much as normal bladder function as possible." The section "Choosing A Program That Fits The Resident After Evaluation:" instructed staff, "If	2 910		

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2 910	Continued From page 41 resident is unsuccessful at toilet training or is unable to participate in retraining than the resident should be placed on incontinence care program. Absorbent products and external collection devices will be used as per center policy in conjunction with incontinence care. Changing programs are also driven by patterns of incontinence." The facility provided procedure lacked instructions regarding the development of care plan or instruction to nursing assistants on bowel care. Bladder: On 1/11/16, at 2:46 p.m. during room observation R13's room was noted to have a musty urine smeel in the room. On 1/13/16, at 6:47 a.m. during a subsequent visit to the room a strong smell of air fresher was noted in the room which masked the urine smell. On 1/14/16, at 7:16 a.m. upon entering R13's room strong urine smell was noted but R13 was not in the room at the time. At 7:17 a.m. when asked what time resident had been assisted to get ready for the day nursing assistant (NA)-B stated 6:45 a.m. At 7:18 a.m. when approached R13 smiled and was talking to surveyor but was heard to be understood. At 7:51 a.m. to 9:12 a.m. R13 remained at the dining room table for breakfast. At 9:12 a.m. R13 was observed seated on wheelchair outside her room. At 9:20 a.m. licensed practical nurse (LPN)-B was wheeled R13 down the hallway to the television (TV) lounge. At 9:25 a.m. R13 was observed wheeling herself down the hallway wandering, appeared lost and confused. At 9:29 a.m. NA-B was observed approach R13 and wheeled resident down the hallway to room. At 9:33 a.m. NA-B and	2 910		

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2 910	Continued From page 42 NA-C approached resident. Then NA-B handed a communication card to resident to read and resident nodded her head then both staff wheeled resident into the bathroom. When NA-B was re-directing resident to use the grab bar resident then attempted to grab NA-B. Both NA's were observed attempt to pursuade 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. During observation both NA's never offered to check and change R13 which was two hours and 45 minutes. -At 9:36 a.m. NA-B wheel resident into the TV lounge and left. At 9:37 a.m. when approached a strong urine smell was noted on resident. At 9:40 a.m. R13 was observed self transfer to a regular chair in the TV lounge. At 9:44 a.m. R13 again self transfer back to the wheelchair then was observed wheeling down the hallway towards the nursing station. -At 9:47 a.m. R13 was observed seated on wheelchair across from the nursing station. -At 9:50 a.m. surveyor approached LPN-B requested to have resident toileted. -At 9:56 a.m. both LPN-B and NA-B went to room attempted to get resident stand in the toilet but resident was still attempting to grab on male staff NA-B. -At 10:04 a.m. LPN-B finally suggested to lay resident down in bed to change resident which was 3 hours and and 15 minutes. -At 10:05 a.m. LPN-B and NA-B assisted resident to bed and as resident stood up LPN-B stated "you needed it." R13's pants and incontinent pad were observed soaked with urine. At 10:13 a.m. LPN-B checked the wheelchair cushion stated "it's a little bit wet." On 1/14/15, at 10:15 a.m. NA-B acknowledged	2 910		

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2 910	Continued From page 43	2 910		

resident had not been toileted timely and was over one hour and 15 minutes from when resident had last been checked and changed. NA-B stated "We are under staffed and some of the residents in the unit need two staff with transfers because they use the transfer machine and some are combative and if two aides go into the room for half hour they is no way I can tell another resident in the middle of cares I have to go now. Someone can point a finger at me but we are under staffed and for 27 residents for two aides with heavy cares it's impossible. I have not even take a 15 minute break and in 20 minutes will be lunch here coming and am shaking."
-At 10:26 a.m. LPN stated NA's were supposed to follow the plan of care and were supposed to toilet the resident timely. LPN-B further stated she would have expected NA-B to report to her he was running late to toilet and resident had refused and she would have attempted to re-approach resident as she did.

R13's diagnoses included schizoaffective disorder, unspecified hearing loss, cerebral infarction without residual deficits, unspecified osteoarthritis, unspecified dementia with behavioral disturbance and conduct disorder obtained from the admission record dated 1/14/16.

R13's Urinary Incontinence Indwelling Catheter Care Area Assessment (CAA) dated 10/14/15, identified resident was incontinent of bowel and bladder, was at risk for urine body odor, urinary tract infections and skin breakdown. R13's care plan dated 11/13/14, identified resident had a functional incontinence of bladder and bowel. Care plan directed staff to provide assistance of one to toilet. Use briefs/pads for incontinence protection and to toilet resident every two hours

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2 910	Continued From page 44 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. R153 was observed on 1/13/16, from 7:00 a.m. until 10:35 a.m. and R153 was not toileted for at least three hours. At 10:09 a.m. 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, "No." At 10:19 a.m. NA-B brought R153 to room after asking permission. At 10:25 a.m. NA-B and NA-D transferred R153 from wheel chair to bed with mechanical lift. There was a strong odor of urine present when R153 was lying in bed. registered nurse (RN)-D was present and verified the 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 with urine and RN-D verified the brief was saturated. NA-D wiped R153's bottom with an incontinence wipe. Brown stool observed on incontinence wipe. NA-D washed R153's peri area from back to front, then applied new incontinence brief. Bladder assessment dated 6/15/15, and reviewed 11/17/15, indicated resident was not appropriate for bowel and bladder retraining program due to diagnosis of dementia, psychosis and unspecified cerebrovascular disease. Staff was to toilet R153 every two hours and as needed. The Urinary Incontinence CAA dated 6/26/15, indicated, "CAA triggered for incontinence r/t	2 910		

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2 910	Continued From page 45 [related to] res. [resident] is incontinent of bowel and bladder, see MDs [sic- Minimum Data Set] ADL [activities of daily living]/continence coding. Res. is at risk for UTI [urinary tract infection], Skin CAA triggered for incontinence r/t res. is at risk for UTI, skin breakdown, unmet hygiene needs." The Alteration in Elimination of Bowel and Bladder, Incontinence of bowel and bladder care plan dated 6/29/15, instructed staff to check and change resident every two hours and as needed. R153's quarterly MDS dated 11/17/15, indicated resident was cognitively intact, required assistance with ADLs, and was always incontinent of bowel and bladder. R153's diagnoses listed quarterly MDS included Stroke, psychosis and mood disorder. Care plan dated 11/18/15, indicated R153 had a physical functioning deficit related to self-care impairment, and mobility impairment. Care plan goals were that R153 would be clean, dry, and odor free. Care plan instructed staff that R153 required extensive assist of one for dressing, personal hygiene, bathing, and toileting. It also indicated R153 had a history of refusing some ADL assistance depending on mood. The undated Nursing Assistant Assignment Sheet for R153 instructed staff that R153 was 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. 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	2 910		

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2 910	Continued From page 46 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. The Bladder Assessment dated 12/22/15, indicated R181 had functional urinary incontinence and was not appropriate for toileting or retraining program because of dementia and immobility. 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. R181's diagnoses included traumatic brain injury and dementia. Urinary Incontinence CAA dated 12/24/15, indicated "CAA triggered dr/t [sic] urine incontinence. Res is at risk for skin break down, UTI. Proceed to care plan to ensure staff aware and provide care PRN [as needed]. Update MD [medical doctor] NP [nurse practioner] PRN." The care plan dated 1/12/16, indicated resident was functionally incontinent of bowel and bladder. It instructed staff to check and change R181 every two and as needed. the undated Nursing Assistant Assignment Sheet for R181 instructed staff that R181 was incontinent and was to be checked and change every two hours and as needed.	2 910		

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2 910	Continued From page 47 During interview on 1/13/16, at 9:49 a.m. NA-B said, "[R153] was our third resident to get up. We started at about 6:45 a.m. and were done about 7:00 a.m. [R153] was taken for activities and had not been asked or refused that morning. [R181] was our first resident to get up at 6:10 a.m. [R181] is laid down and changed after breakfast then at 11 a.m. Then at 1:00 p.m. [R181] is every two hours for changing and repositioning. [R181] does not refuse toileting." - At 9:56 a.m. LPN-B said R153 was to be repositioned every two hours and check and change every two hours. R153 could also ask to be changed. LPN-B acknowledged R153 had not been toileted in over two hours. LPN-B stated LPN-B would have someone take care of it right away. R181 was to be checked and change every two hours. - At 10:11 a.m. NA-E stated we got R153 up around 6:30 a.m. - At 10:13 a.m. RN-D stated R153 was to be repositioned every two hours and offered to be changed every two hours. - At 2:47 p.m. NA-B stated was working a double. NA-B stated, "Right now we are short staffed." When asked about assisting residents to the bathroom and to be repositioned NA-B said, "You cannot always do the every two hours turning and repositioning and changing because you need two people and then it takes you 15 to 30 minutes and you need to do the next one. How can you fix it?" - At 2:55 p.m. NA-D said "I don't always have time to do the repositioning and toileting every two hours. We are so busy right now. We do our best." NA-D said, "I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick." - At 9:22 a.m. the director of nursing services said, "I expect the staff to follow our policy	2 910		

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2 910	Continued From page 48 regarding incontinence care I expect them to check and change residents in accordance to their care plans." R153 and R181 was not provided incontinent cares. Facility procedure Incontinence Management/Bladder Function Guideline effective date 1/19/15, Indicated the purpose of a bladder management program is to:..." Manage urinary incontinence, restore or maintain as much as normal bladder function as possible". The section "Choosing A Program That Fits The Resident After Evaluation: "Instructs staff If resident is unsuccessful at toilet training or is unable to participate in retraining than the resident should be placed on incontinence care program. Absorbent products and external collection devices will be used as per center policy in conjunction with incontinence care. Changing programs are also driven by patterns of incontinence." The undated Golden Clinical Services Skin integrity Guideline instructed staff to "reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care" and "Care plan is to be implemented, evaluated and revised based on the needs of the resident." SUGGESTED METHOD OF CORRECTION: The facility could review the state requirements, review their policies/procedures and revise them to include individualized toileting schedules/plan/program, the facility could then develop assessments and tools and educate staff on how to assess, implement, and maintain an individualized toileting plan for all residents. The	2 910		

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2 910	Continued From page 49 facility could then develop and implement an auditing system as part of the quality assure process to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food sanitation procedures were followed to minimize the possibility of food borne illness in the main kitchen and in 6 of 7 kitchenettes. This had the potential to 171 of 175 who were served food and/or fluids out of 6 of 7 kitchenettes and the main kitchen. Findings include: During the kitchen and facility tour on 1/11/16, at 11:48 a.m. to 12:52 p.m. with the director of dietary (DD) the following was observed: - Hobart Stand up mixer stationed next to the oven was observed to have a clean mixing bowl in place but white hardened food splatter and heavy buildup of white food debris around the bottom arm, backside and on and around the underside of the mixer. Food would come in	21015	corrected	2/23/16

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21015	Continued From page 50	21015		

contact with the debris. The DD verified the mixer needed to be cleaned, stating "It was used yesterday" after asking one of the staff he then asked one staff to clean it.

-The dishwasher was observed to have heavy white flaky porous lime build up all around the dishwasher and on the inside of the clean side. Inside the dishwasher on the clean side was observed a chute/vent that had heavy porous lime build up which flaked off with touch. DD verified stated the dishwasher was de-limed once a week and then after each use the staff cleaned it.

-Three 32 gallon Brute trash cans stationed between the steamer and food warmer; between the gas stove and oven and another between the food prep station and the one compartment sink across from the gas stove and oven which was approximately 22 inches were all three observed to be dirty, covered with heavy amounts of food debris and spatters in the entire outside of the cans.

-Two large frying pans were observed on the stored and the inside of both had heavy buildup of a black substance on the cooking surface of the pans. DD verified stated they were going to be cleaned. On a follow up tour on 1/12/15, the two frying pans were again observed on the stove still with heavy black buildup on the inside cooking surface and the entire side.

-The dishwasher was observed to have heavy white flaky porous lime build up all around the dishwasher and on the inside of the clean side. Inside the dishwasher on the clean side was observed a chute/vent that had heavy porous lime build up which flaked off with touch. DD verified stated the dishwasher was de-limed once a week

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21015	Continued From page 51 and then after each use the staff cleaned it. 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 dietary 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 slowly dripping near the spout and noted to have stagnant 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 there 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. 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. 2 South kitchenette, the resident microwave was observed with brown dried on food spatters in the	21015		

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21015	Continued From page 52	21015		

inside. In addition the resident toaster was observed with heavy buildup deposits of greasy old bread crumbs in the inside of the toaster grates. DD verified stated toasters were supposed to be cleaned daily. Acknowledged the heavy bread crumbs buildup.

2 East fridge kitchenette, the resident refrigerator was observed with dried juice spills around the door seal in the inside and at the bottom underneath the crispy drawers a heavy brown dried buildup was noted. In addition, the resident toaster was noted with heavy deposits of bread crumbs in the inside grates DD verified stated would be cleaned.

On 1/11/16, at 5:30 p.m. during a follow up kitchen tour, the steamer glass door was observed to have been cleaned however a white build up coating remained in the inside and door. Upon the cook opening the steamer for meal set up the aluminum foil used to cover the stainless steel containers were all observed to have white dried on stains. When asked what the stains were DD and cook both stated was from the steam condensation in the steamer.

On 1/13/16, at 9:58 a.m. during a follow up tour the frying pans were observed turned upside down on the stove. DD was requested to turn them over and both were observed still with heavy substance on the cooking surface and the entire sides. DD stated they still needed to be cleaned. Immediately DD had one of the dietary aides clean them. At 10:16 a.m. dietary aide was observed cleaning the frying pans with steel cleaner then was seen use a scrape but was not able to get the black buildup off. DD then was heard ask the dietary aide to throw the frying pan out and stated he had ordered new ones to

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21015	Continued From page 53 replace the two. DD acknowledged the findings and policies and the manual for the steamer were requested DD stated he had spoken with the company representative who had indicated the buildup would also come back. DD and surveyor opened the steamer and DD verified the lime buildup and verified on the bottom of the steamer was a thin film of dust that was collecting. Sanitation Overview policy reviewed 2/12/2015, indicated "It is the policy of the Dining Services department to practice proper sanitation techniques for clean equipment to prevent the outbreak of foodborne illness, and to train Dining Service employees to use these techniques... Food code 4-601.11Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils.* (1) Equipment, food-contact surfaces, and utensils must be clean to sight and touch. (2) The food-contact surfaces of cooking equipment and pans must be kept free of encrusted grease deposits and other soil accumulations. (3) Non-food-contact surfaces of equipment must be kept free of an accumulation of dust, dirt, food residue, and other debris..." SUGGESTED METHOD OF CORRECTION: The director of dietary services could develop a cleaning schedule for all areas of the kitchen and develop a system to audit compliance with the schedule. The director of dietary services could also provide education to dietary staff on the prevention of food borne illness through good sanitary practices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21375	Continued From page 54	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure equipment and work surfaces were kept clean and sanitary for 1 of 5 units in which 50 residents resided. In addition, the facility to ensure proper handwashing was performed for 2 of 4 residents (R153, R181) who were observed for cares. Findings include: On 1/13/16 at 7:13 a.m. a medication set up and administration was observed for R93, during the set up registered nurse (RN)-K performed hand hygiene, poured a class of room temperature water for R93 and set it on top of the 2 East nursing station desk while she prepared 7 medications, she then picked up the glass of water and added more water to it, then picked up the medication cup and entered R93's room. The top of the nursing station desk had tape debris and black debris was stuck to it. RN-K moved between the medications and the cup of water without additional hand hygiene. On 1/13/16, at 10:00 a.m. licensed practical nurse (LPN)-F verified the Silent Knight Pill crusher had debris in the crushing area, and along the sides of the pill crusher. The debris was white, brown	21375	corrected	2/23/16

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21375	Continued From page 55	21375		

and black and could be scraped off with a fingernail. The pill crushers were on top of the three medication carts, in an area used for medication preparation. LPN-F further verified the top of the nursing station desk had tape debris and black debris was stuck to it. The medication carts were placed in front of the 2 East nursing desks and medications were sometimes dispensed form the desk area.

The Cleaning and Disinfection of Resident-Care Items and Equipment policy dated 8/2014, directed:
"Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.
1. c. Non-Critical items can be decontaminated where they are used.
7. Intermediate and low-level disinfectants for non-critical items include:
a. ethyl or isopropyl alcohol;
b. Sodium hypochlorite;
c. Phenolic germicidal detergents and
d. Iodophor germicidal detergents;
e. Quaternary ammonium germicidal detergents."

Incontinence care:
R153's quarterly Minimum Data Set (MDS) dated 11/17/15, indicated resident was cognitively intact, required assistance with activities of daily living (ADLs), and was always incontinent of bowel and bladder.

During observation of incontinence cares on 1/13/16, from 10:25 a.m. until 10:35 a.m. and registered nurse (RN)-D present for entire

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21375	Continued From page 56	21375		

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 with urine. RN-D verified brief 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. NA-D washed R153's peri area from back to front, then removed the soiled gloves and put new gloves on without washing hands. NA-D applied new incontinence brief. NA-D put blue boots on R153's feet and pulled up covers, then removed gloves, straightened room and put new gloves on. NA-D closed the plastic bag with soiled brief and incontinence wipes and took them to the soiled utility room and then NA-D their washed hands.

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.

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NA-D pulled R181 out of dining room and took to room. 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. 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. NA-D used an incontinence wipe to wipe the perineum from front to back. NA-E and NA-D rolled R181 to right side. NA-D wiped R181's bottom from back to front. No stool visible on incontinence wipe.
NA-D removed the soiled gloves, put on new gloves without washing hands or using sanitizer. NA-D put R181's pants and blue boots on. NA-D covered resident up. NA-D applied a new pair of gloves without washing hands and washed R181's eyes and face.

During interview on 1/13/16, at 2:55 p.m. NA-D stated, " I know I am to wipe from front to back, but I wiped both of them from back to front. I am not sure why. They could get sick. "

During interview on 1/14/16, at 9:22 a.m. the director of nursing services expected staff to at least use hand sanitizer when staff remove gloves as long as the gloves are not visible soiled. If the gloves are visible soiled 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

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21375	Continued From page 58 12/9/15, instructs staff: "11. Female perineal care a. If resident is soiled with feces, place resident on side and clean perineum and rectal area. b. Change water and discard soiled linen appropriately. c. Change gloves. d. Turn resident on her back e. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on the 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 on bedpan and pour clean warm water or cleansing solution over the vulva and perineum. 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. Wound Care R153's wound care was observed on 1/14/16, at 7:29 a.m. R153 was sitting in wheelchair. The left ankle and heel covered with gauze. The bottom of left great toe was purple. Licensed practical nurse (LPN)-B washed hands and put on gloves. LPN-B used a bandage scissors from their pocket to remove the soiled gauze dressing. LPN-B did not clean the scissors prior to use. There was scant amount of drainage or ointment observed on the gauze. LPN-B cleaned R153's left ankle wound with normal saline and gauze. LPN-B removed the soiled gloves and put new gloves without washing hands. LPN-B wiped the area surrounding the wound with a barrier wipe, then reached into dressing supply caddy with the	21375		

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soiled gloved hands and removed an open square of alginate, foam 2 cm by 2 cm dressing and a roll of gauze. LPN-B cut the clean alginate (a natural wound dressing) with the same soiled scissors that cut the soiled gauze dressing. LPN-B applied Santyl (a sterile enzymatic debriding ointment) using a cotton tipped swab, covered with alginate, then applied foam dressing and wrapped with gauze. LPN-B removed R153's sock on right foot and wiped right heel with skin prep sponge. The right heel observed to be intact without redness or open areas. LPN-B placed the soiled scissors back into the pocket without disinfecting the scissors, removed the soiled gloves and washed their hands.

During interview on 1/14/16, at 8:01 a.m. LPN-B stated, "Generally I do not wash hands between glove changes. I am not sure, I did not think I needed to. I did not wipe my scissors off after cutting off the old dressing and before cutting the alginate. I did reach into the dressing supply caddy with my gloves on after I had cleaned the wound."

During interview on 1/14/16, at 9:22 a.m. the DNS said staff should have wiped the scissors of with alcohol after being used. DNS said, "I expect staff to change gloves before reaching into a bucket of clean dressing supplies. Gloves should be changed and hands cleaned with sanitizer or soap and water after completing one wound dressing, before doing another treatment or whenever they remove their gloves."

The facility Handwashing/Hand Hygiene procedure revised August 2014, instructed staff to:
" 7. Use an alcohol-based hand rub containing at least 62% [percent] alcohol, or, alternatively, soap

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21375	Continued From page 60 (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before after and direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident: and m. After removing gloves. n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; 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." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to infection control concerns while passing medications, performing wound care, perinal	21375		

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21375	Continued From page 61 cares and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by:	21630		2/23/16

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21630	Continued From page 62 Based on observation, interview, and document review, the facility failed to ensure narcotic medications were counted appropriately in 1 of 3 units reviewed for medication storage. In addition, the facility failed to ensure expired medications were disposed of in a timely fashion. This had the potential to affect 132 of 175 residents in the facility. Findings include: R26 was admitted to the facility on 12/25/14, with admission diagnoses of acute respiratory failure and major depression. The Physician Orders indicate Lorazepam (antianxiety medication) Intensol solution was ordered 1/6/15, R26 received 1 dose in January 2015, 16 doses in February 2015, zero doses in March 2015, zero doses in April 2015, zero doses in May 2015, zero doses in June 2015, zero doses in July 2015, 2 doses in August 2015, zero doses in September 2015, zero doses in October 2015, zero doses in November 2015, zero doses in December 2015, and was discontinued 1/5/16. However, the Lorazepam Intensol solution remained in the secured medication refrigerator until discovered 1/13/16. The annual Care Area Assessment (CAA) dated 7/9/15, indicated changing cognitive function and depression. The care plan dated 7/22/15, indicated impaired cognitive function and impaired communication. The Minimum Data Set (MDS) dated 9/18/15, indicated R26 was severely cognitively impaired, and was totally dependent on staff for bed mobility, toilet use, and dressing. On 1/13/15, at 1:00 p.m. during a review of medication storage room in the 1 North nursing	21630	corrected	

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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/milliliter 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 book the record could be found. There were 3 numbers written on the box, 84, 127, and 35. Page 84 indicated 13 mls should have been in the vial.

Both RN-H and RN-G had participated in the morning narcotic count which 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 though RN-G and RN-H had signed the narcotic books as if a full and accurate count had been completed. The Lorazepam Intensol had last been administered on 8/28/15 (more than 4 months prior).

On 1/13/15, at 1:19 p.m. the director of nursing service (DNS) arrived on the floor. DNS verified she had just been informed of the key broken off in the padlock, and that no-one had reported that to her previously. DNS verified the narcotic count was supposed to be a visual count and verification of the medications on the unit, and it

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had not been completed accurately. DNS stated she did not believe any Lorazepam Intensol had been diverted (and that it was considered a drug of abuse and that was why it had been locked up).

On 1/13/15, at 1:38 p.m. DNS located page 5 in another medication cart and narcotic book, which showed the 13 mls, an additional three doses had been administered, last on 8/28/15 (3 months after the medication should have been destroyed) and the new volume total was now 12.25 mls. The Lorazepam Intensol solution should have been destroyed at the end of May 2015, (7 months ago). The DNS stated the medication was supposed to be destroyed and she had just not had time yet. The destroy [request] was dated 12/5/15. The DNS verified the consultant pharmacy service performed periodic medication room inspections and audits for the facility.

The delivery label was unable to be read, the medication had first been administered on 2/20/15 at a volume of 22 ml. R26 had moved to 5 different rooms in the facility, and the documentation of the medication use was unable to be fully provided at that time (the notes indicating where the medication had been transferred were not present). DNS verified the narcotic medication books lacked documentation of what page and what medication cart the medication had been moved to, the narcotic books contained duplicate pages that were not completed.

It was unable to be determined when the key had broken off in the padlock, as the narcotic counts did not include all of the secured medications on the unit.

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21630	Continued From page 65 On 1/14/16, at 12:30 p.m. the consultant pharmacist (CP) stated he had taken over the building in July, so January 2016 would have been an audit of the medication rooms. He was unsure when the previous pharmacist last audited. CP stated he was not aware of the 90 day expiration for the Lorazepam Intensol, and stated if it was a multi-dose vial it should be good until the manufacturer ' s expiration date. If it had been compounded, the expiration would be much sooner. CP stated the plan of correction would be to audit all the fridges quarterly. According to the package insert from RLI dated 2012, the Lorazepam Intensol should be stored at 36-46 degrees Fahrenheit and discarded 90 days after the medication was opened. The Storage of Medication policy dated 1/6/15, directed: "Medications and biologicals are stored properly, following manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administration. The medication supply is accessible only to licensed personal, pharmacy personal, or staff members lawfully authorized to administer medications." 1. Medications are kept in controlled environment, and may include medications carts, medication rooms, medication cabinets, or other suitable containers. 2. Non-controlled medication that have been identified by the nursing care center, as having the potential for abuse may also be stored with controlled substances. [Lorazepam Intensol solution]. 11. Mediations requiring refrigeration or temperatures between 36-46 degrees Fahrenheit are kept in a refrigerator with a thermometer.	21630		

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21630	Continued From page 66 14. "Outdated or contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. 16. "Medication storage conditions are monitored on a regular basis as a random quality assurance ("QA") check. Recommendations are made for corrective action taken as problems are identified." SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing could in-service all staff responsible for medications the need to secure medications and follow disposal of medications according to the facility policy/procedure. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain handrails that were free of splinters on outside of rooms 207 (2N had 29 residents) and 232 (2S had 30 residents which could have been affected), staff, and visitors on the units, a clutter free environment in room 240B and 268B, and tangled	21665	corrected	2/23/16

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21665	Continued From page 67 electrical cords in room 383B and had the potential to cause 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: - Handrails outside of rooms 207 and 232 were splintered and had sharp wooden edges - Rooms 240 B and 268 B had a huge amount of personal items, clutter, in boxes in disarray - Room 383B had a numerous black electrical cords near an outlet that looked like spaghetti and had the potential to cause an accident or injury. The facility's policy on Hoarding, effective date 11/18/15, indicated "Hoarding is a persistent difficulty in either collecting or parting with possessions because of a perceived need to save them to the point of creating distress." "For immediate management: - review health and safety issues with the resident if able to understand or with the family/friend; - offer sealed containers for storage if the resident insists on storing food in room, - assess and address reasons for hoarding, - off to "trade" with the resident for another item if necessary." "For long term management: - If the resident is able to understand, create a contract for not taking items back to room or for allowing a cleaning schedule. Identify areas of the room appropriate for storage.	21665		

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21665	Continued From page 68 - If the resident is capable of understanding, come to an agreement that if items are brought back to the room another must be returned in its place. - Limit the availability of extra items resident tends to take (extra silverware or condiment packets, etc.) -Set a routine for checking for hoarded items. If at all possible, this should be done with the resident present to help develop a trusting relationship rather than have the resident "discover" that some of his/her objects are missing. Arrange for family/friend/clergy or other trusted person to assist. - Reinforce positive behavior - Anticipate needs so perceived need is met." During the tour, the director of maintenance confirmed the above observation of cluttered rooms, splintered handrails, and multiple electric cords in one area. The director of maintenance stated that he could use ties to separate the electrical cords and tidy up the cords, the handrails could be sanded, and that the facility had a policy on hoarding. The director of maintenance indicated that staff were to work with the residents in keeping the clutter down and organized. SUGGESTED METHOD OF CORRECTION: The DM could review and revise the policies, educate maintenance staff and identify trends of repeated building disrepair. The DM could work with the Director of nursing (DON) to ensure staff are reporting environmental issues appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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21685	Continued From page 69	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent a noisy enviroment for 1 of 2 residents (R48) who complained of noise. In addition, the facility failed to maintain a safe, sanitary, free of urine odors, and homelike environment. This had the potential to affect 132 of 175 residents in the facility. Findings include: R48's toilet was running continuously, since her admission date 11/13/15. R48 had told several staff members about the running water and the noise, no one came to fix the running water and now R48 kept the door to her bathroom closed so she would not hear the running water. R48's was interviewed on 1/11/16, at 2:21 p.m. and when asked about comfort, light, and sound levels, R48 stated that she wanted someone, anyone, to come in and fix the running water in the toilet in her bathroom. R48 stated that she was admitted to the facility on 11/13/15, and the water had been running nonstop in her toilet since then. The resident indicated had told several staff members (but could not remember any names)	21685	corrected	2/23/16

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21685	Continued From page 70	21685		

when they would come in her room and provide cares and nothing was done to stop the running water. The bathroom was checked and the water was running in the 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.

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 noted to need attention:

- The carpet in the hallways was worn and had numerous spots throughout and hallways walls had numerous gouges and black marks on the wallboard on 4 of 4 units on second floor.

- Room 116A had a large gouge in the wall board behind the bed
- Room 209 - the entrance door to the room had a deep gouge with jagged edge
- Room 282 missing tile by the bathroom door, and a bathroom had raised area for the toilet had missing tiles on the upper edge, and the floor was dirty

The following areas had a urine odor:
- 209 B strong urine smell in the bathroom
- 211A strong urine odor in room
- 222B/223B strong urine odor in room (shared bathroom)

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21685	Continued From page 71 - 233A strong urine odor in room - 378 A urine odor in bathroom At the beginning of the tour on 1/14/16, at 10:00 a.m. the director of maintenance clarified that there were no pending projects for the facility after the remodel was done on first floor to be completed in 2/16. The third floor has been completed and the hopes would be to remodel and update the second floor in the future. At the end of the tour the Director of Maintenance agreed with the environmental issues as listed. The Director of Environmental Services gave the writer a copy of the carpet cleaning schedule for 01/16. The carpet was to have Extract cleaning on 1/6/16 2E, 1/13/16, Extract Center Hall, 1/20/16 Extract 2S, and 1/27/16 Extract 2N. Extraction was the process to clean spots in the carpet. All hallways were to be done on Fridays (one unit each Friday). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's environment is maintained in a safe, clean and sanitary manner. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21735	MN Rule 4658.1420 Solid Waste Disposal Solid wastes, including garbage, rubbish,	21735		2/23/16

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21735	Continued From page 72 recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not create a nuisance or fire hazard, nor provide a breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper containment of garbage in the outside dumpster to prevent attracting pests and rodents. This had the potential to affect all 175 residents residing at the facility. Findings include: On 1/12/16, at 11:10 a.m. during a tour to the facility main garbage dumpster the area was observed littered with slices of bread, multiple soiled gloves, used incontinent products all around the main dumpster and underneath the main dumpster. On 1/13/16, on a subsequent visit to the area with the director of dietary the area remained the same heavily littered as noted on the previous day. During the tour the district manager and another staff were in the area walked all around the dumpster the district manager verified the area was heavily littered around and underneath and a mattress was lying next to the dumpster. When asked who was responsible for cleaning the area the district manager stated was a group effort. When asked who was responsible for ensuring the area was clean was not really able to answer and stated was going to have the area clean.	21735	corrected	

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21735	Continued From page 73 On 1/14/16, at 11:00 a.m. the director of dietary stated his staff had been trained to ensure all the garbage was disposed of properly and if the staff noticed the area was littered they were supposed to assisting with cleaning the area and make sure there was no garbage lying around. Waste Disposal policy reviewed 2/12/15, indicated "The Dining Service department will hold, transfer and dispose of waste in a manner that does not create a nuisance or breeding place for insects and rodents, or otherwise permit the transmission of disease." The policy directed staff to "Keep dumpster and dumpster site areas clean and free of debris." SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop, review, and/or revise policies and procedures to ensure the proper storage and disposal of garbage is maintained. The maintenance director or designee could educate all appropriate staff on the policies and procedures. The maintenance director or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21735		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		2/23/16

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21805	Continued From page 74 This MN Requirement is not met as evidenced by: 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. Findings include: R181's admission Minimum Data Set dated 12/22/15, indicated the resident had moderate cognitive impairment and required staff assistance with eating. R181's diagnoses included traumatic brain injury and dementia. R181's care plan dated 1/6/16, directed staff to encourage independent eating as able, feed resident as needed. Speech therapy clarification diet order dated 12/21/15, directed staff R181 was to receive pureed food and honey thick liquids. During observation on 1/11/15, at 6:35 p.m. nursing assistant (NA)-D was observed feeding R181 pureed turkey, mashed potatoes with gravy and pureed green beans and a honey thick beverage. NA-D was observed standing the entire time NA-D was feeding R181. During interview on 1/13/16, at 2:55 p.m. NA-D stated, "I thought I could feed more quickly if I stood while feeding [R181]. I did not talk to [R181]. No one ever told me I could not stand while feeding a resident." During interview on 1/14/16, at 3:00 p.m. the director of nursing (DON) stated it was her expectation that staff would sit while feeding residents.	21805	corrected	

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21805	Continued From page 75 The facility Eating Support procedure dated 1/26/15, instructed staff: "Never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible." SUGGESTED METHOD OF CORRECTION: The DON or social services could in-service all staff on the need to treat all residents with respect and dignity. The Quality Assessment and Assurance committee could develop a system to audit employees for dignified care and services toward residents in the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach and available for use for 1 of 1 resident (R125), who utilized their call light for	21810	corrected	2/23/16

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assistance from staff. In addition failed to ensure 3 of 4 residents (R19, R153, R181) had appropriate season and proper fitting clothing reviewed for activities for daily living (ADLs)

Findings include:

R125 was observed on 1/11/16, at 4:10 p.m. and during the interview R125's call light was observed laying on the floor at the base of the bed. When asked if she was able to use the call light to ask for help resident stated she used it all the time. R125 stated she was not able to reach it at the time.
-At 4:11 p.m. licensed practical nurse (LPN)-A stated R125 used her call light at times to call staff in. LPN-A went to room with surveyor and verified the call light was not at reach, then pulled it off the floor and pushed the button to make sure it worked and handed it to R125. When asked if she was able to use the call light R125 stated "Yes. All the time."
-At 4:13 p.m. when asked if call light had been put at reach when observed early assisting R125 nursing assistant (NA)-A stated he was not sure as he had left the room and was going to ask the other NA.

R125's fall Care Area Assessment (CAA) dated 8/13/15, indicated resident had fall prior to coming to nursing home. CAA indicated R125 used a mechanical lift for all transfers, was at risk for falls with potential for fracture and/or serious injury and further debilitation.

The fall care plan dated 8/13/15, indicated R125 was at risk for falls, had sustained head laceration from falls, had history of falls, had impaired cognition, impaired physical ability and had generalized weakness. The care plan

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21810	Continued From page 77 directed staff to ensure call light or personal items were available and in easy to reach. On 1/14/16, at 2:00 p.m. the director of nursing services (DNS) stated if a resident had a care plan indicating the call light was supposed to be at reach then it was supposed to have been at reach. Call light policy reviewed 1/8/15, directed staff "Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand." R19 was dressed in inappropriate clothing for winter weather and her bed linens were very thin and worn with specks of blood on the top blanket on her bed. On 1/11/16, at 3:58 p.m. the resident was observed sitting on her bed with a very thin dress that came to above the knees. R19 was wearing a pair of gripper socks. The top bed linen, a blanket, was observed to have small blood stains and R19 was noted to be inserting a finger into a nostril. On 1/13/16, at 7:29 a.m. R19 was observed sitting by the dining room table. R19 was neatly dressed with a thin white tee shirt, no bra and a pair of light weight blue elastic waist band pants. Resident stated that she was hungry and waiting for breakfast. Registered nurse (RN)-B was interviewed on 1/13/16, at 7:38 a.m. and confirmed R19 had a thin tee shirt on and light weight pants. In addition, RN-B confirmed the blood spots of R19's bed linens and stated that the bed linens should be changed as needed when dirty and	21810		

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21810	Continued From page 78 R19's bed linens should have been changed. In addition, RN-B confirmed the resident's linens are changed on bath day and R19's bath day was on Monday, 1/11/16. On 1/13/16, at 7:44 a.m. NA-G stated bed linens were changed every bath day. NA-G was in R19's room and saw the blood on the top blanket and stated, "I will change the linens now." NA-G had a clear plastic bag which she put the soiled linen in as she stripped the soiled linen from R19's bed. NA-G indicated that the resident frequently inserted her finger into a nostril and then put the content from the nostril on the bed linen. The director of social services (Dir of SS) on 1/13/16, at 12:43 p.m. confirmed R19 had a court appointed guardian, and had no family. The Dir of SS further indicated R19 did not want to wear a bra. A licensed social worker (LSW) reviewed R19's clothing in her closet and dresser on 1/13/16, at 12:57 p.m. The LSW agreed R19 did not have any underwear in her dresser, only incontinent briefs. R19 had approximately ten very thin summer blouses and ten summer pants. The LSW agreed R19 only had a winter coat for winter clothing in her closet. The LSW stated she would call the R19's guardian and review the need for additional clothing for R19 that was more appropriate for the winter weather. On 1/13/16, at 2:40 p.m., the LSW indicated R19 had a history of refusing showers, personal cares, changing clothing and wearing a bra. The LSW indicated she had spoken to R19's guardian. The guardian at first was reluctant to spend money on clothing because she was spending money on a music therapist for the resident. However, after	21810		

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additional consideration, R19's guardian indicated to the LSW that she would give the facility money to buy R19 winter clothing.

The DNS was interviewed on 1/14/16, at 10:00 a.m. and indicated she expected the nurses would contact the LSW when a resident was in need of clothing appropriate for age, fit, and weather and then the LSW would contact the guardian.

R153's quarterly Minimum Data Set (MDS) dated 11/17/15, indicated resident was cognitively intact, required assistance with activities of ADLs, and was always incontinent of bowel and bladder.

During observation on 1/13/16, from 7:00 a.m. until 10:35 a.m. and the following was noted:
- 7:00 a.m. R153 sitting in dining room. R153 wearing black pants that were unzipped leaving the abdomen exposed. R153 had a gray and black shirt that did not cover abdomen. R153 had a black sweater and gray blanket over shoulders.
- 7:15 a.m. NA-E walked by R153 and did not adjust clothing.
- 7:25 a.m. NA-E walked by R153 and did not adjust clothing.
- 7:55 a.m. a registered dietician adjusted R153's shirt.
- 8:01 a.m. R153's breakfast arrived, pancakes with ground sausage. R153 ate the pancakes with fingers. Abdomen exposed NA-D walked by without adjusting R153's clothing.
- 8:13 a.m. R153 sleeping at table, abdomen exposed from above the umbilicus to under abdominal fold, top of incontinence brief visible.
- 8:16 a.m. NA-E poured milk at R153 s table and did not adjust R153's clothing.
- 8:17 a.m. LPN-B pulled R153's shirt down. The

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21810	Continued From page 80 shirt covered the umbilicus but did not cover entire abdomen and started to roll up immediately. - 8:26 a.m. R153's umbilicus exposed, LPN-B and NA-B walked by R153 without adjusting clothing. - 8:29 a.m. LPN-B adjusted R153's clothing. - 8:35 a.m. R153's shirt rolled up to expose abdomen. - 8:40 a.m. LPN-B unfolded blanket and arranged it to cover R153's abdomen, chest and shoulders. On 1/14/16, at 8:10 a.m. R153 was observed sitting in the dining room wearing a blue shirt and black pants. R153's abdomen was partially exposed. On 1/14/16, at 12:25 p.m. R153 was observed in the dining room wearing a blue shirt and black pants, abdomen exposed up to the umbilicus. Staff in dining room passing meals. R181's admission MDS dated 12/22/15, indicated the resident had moderate cognitive impairment and required staff assistance with activities of daily living. R181's diagnoses included traumatic brain injury and dementia. Observation on 1/11/15, at 5:59 p.m. resident was observed in the hallway with the speech therapist (SLP). R181's shirt was very loose with a plunging V neck. R181's abdomen was showing. The SLP had brought resident back from therapy with a hospital gown draped over her front upside down. The therapist stated resident was cold. RN-D removed the gown and adjusted the shirt by pulling extra material behind R181's back, so it was not so low cut and abdomen was not	21810		

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21810	Continued From page 81 showing. RN-D offered R181 a blanket. R181 stated, "I thought I was warm." On 1/13/15, at 7:00 a.m. R181 was observed sitting in dining room. R181 was wearing a brown patterned boat neck shirt and a red infinity scarf. - 8:10 a.m. the SLP was working with R181. - 8:24 a.m. the shirt had slipped off right shoulder which exposed R181's shoulder exposed. The SLP was still working with resident. - 8:40 a.m. R181 was sitting at the table and the right shoulder was exposed. During an interview on 1/14/16, at 11:47 a.m. NA-B said indicated R153's clothing did ride up her body. "Most of them are too small. We try to pull them down and redirect her to larger shirts." NA-B was also interviewed about R181's clothing and acknowledged the clothes were too big. "I think she has lost weight. She has a lot of beautiful clothing. We select the clothing. All of the tops she has worn today have been too big." On 1/14/16, at 11:49 a.m. the Alzheimer care director-B stated if a resident needed larger or smaller clothing usually a family members were contacted to bring clothing. Alzheimer care director-B stated the system for ensuring resident had clothing that fits was "I ask staff to let me know if a resident needs something then I let the family know. If the resident does not have family, I will help the resident purchase stuff if they have the funds, go through lost and found or purchase stuff myself. [R153] went down yesterday and got elastic pants I noticed it yesterday. I will call [R153's] guardian and follow her guidance. [R181] has a guardian. She was a fashion designer. She likes things this way. We know that being well dressed was important to her. We will work with nursing assistant to thin out closet so	21810		

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 82 she has a lot of clothes. She has been here around 30 days. I don't know why we have clothing on that is too big. During [interdisciplinary team] IDT meetings we review all residents weekly and ask do they need anything." On 1/14/16, at 11:47 a.m. NA-B stated R153 liked her Twins shirt and cat shirt. NA-B stated R153 clothing did ride up most of time and thought was too small. NA-B stated "We try to pull them down and redirect her to larger shirts and have told the director." NA-B acknowledged R181's clothes were too big "I think she has lost weight she has a lot of beautiful clothing. We select the clothing. All of the tops she has worn today have been too big." On 1/14/16, a policy was requesting for resident clothing but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that policy and procedures are up to date, that staff are trained and that call lights and appropriate dress wear are monitored to assure the achieve their highest well being. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		