DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 7D8B

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

	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY	AGENCY		Facility ID: 00915
1. MEDICARE/MEDICAID P. NO.(L1) 245386 2. STATE VENDOR OR MED		3. NAME AND AI (L3) GOLDEN L (L4) 2957 REDW	IVINGCENTE OOD AVENU	ER - SLAY		56172	4. TYPE OF A 1. Initial 3. Termination 5. Validation	2. Recertification on 4. CHOW
(L2) 660385800 5. EFFECTIVE DATE CHANG (L9) 04/01/2006	GE OF OWNERSHIP	(L5) SLAYTON, 7. PROVIDER/SU 01 Hospital		ORY 09 ESRD	02 (L7) 13 PTIP		7. On-Site Vi	
	04/28/2016 (L34) S: (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR 1	
11LTC PERIOD OF CERTIFICE From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	55 (L18) 55 (L17)	Compliance1. A B. Not in Comp		am	2. Tecl 3. 24 F 4. 7-D: 5. Life	nnical Personnel	7. Medie	e of Services Limit cal Director nt Room Size
14. LTC CERTIFIED BED BRE	FAKDOWN	Requirements	and/of Applied v	varvers.	* Code:	A MFFTS	(LIZ)	
18 SNF 18/19	9 SNF 19 SNF 55	ICF	IID		1861 (e) (1) o		(L15)	
(L37) (L37)	38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENC	Y REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE	E	Date :			18. STATE SUI	RVEY AGENCY	APPROVAL	Date:
Joseph Garvey	y, HFE Nursing Ev	II 0	05/02/2016	(L19)	K <u>amala Fiske-I</u>	Downing, Heal	th Program Rep	oresentative 05/02/2016 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OF	R SINGLE S	TATE AGENC	YY .
19. DETERMINATION OF EI 1. Facility is Eligi 2. Facility is not	ible to Participate		MPLIANCE WITH	I CIVIL	2. (FA-2572) 2 Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 01-Merger, Clos			OLUNTARY iail to Meet Health/Safety
(L24)	(L41)		(L25)			on W/ Reimburse		Fail to Meet Agreement
25. LTC EXTENSION DATE:		IVE SANCTIONS n of Admissions:	(L44)		03-Risk of Involution 04-Other Reason	untary Termination for Withdrawal	07-F	<u>HER</u> Provider Status Change Active
(L2	B. Rescind S	uspension Date:	(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		00454						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-153	39 32	2. DETERMINATION	V OF APPROVAL	DATE				
	(L32)			(L33)	DETERMIN	ATION APPF	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245386

May 2, 2016

Ms. Theresa Pridel, Administrator Golden LivingCenter - Slayton 2957 Redwood Avenue South Slayton, MN 56172

Dear Ms. Pridel:

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 April 15, 2016 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

April 29, 2016

Ms. Theresa Pridel, Administrator Golden LivingCenter - Slayton 2957 Redwood Avenue South Slayton, MN 56172

RE: Project Number S5386026

Dear Ms. Pridel:

On March 25, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 30, 2016. (42 CFR 488.422)

In addition, this Department recommended the following remedy to the CMS Region V Office for imposition:

• Per instance civil money penalty for the deficiencies cited at F157, F309, and F314. (42 CFR488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on March 10, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 10, 2016, as of April 15, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 15, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 25, 2016:

•Per instancw civil money penalty for the deficiencies cited at F157, F309, and F314 remain in effect (42 CFR 488.430 through 488.444).

Golden LivingCenter - Slayton April 29, 2016 Page 2

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fishe Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building B. Wing		Y2	4/28/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - SL	AYTON	2957 REDWOOD AVENUE SOUTH			
		SLAYTON, MN 56172			

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).

ITEI Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix F		Correction	ID Prefix			Correction
Reg. #	483.10(b)(11)	Completed		83.13(c)(1)(ii)-(iii), (c)(2) (4)	Completed	Reg. #	483.13(c)		Completed
LSC		04/15/2016	LSC		04/15/2016	LSC			04/15/2016
ID Prefix	F0274	Correction	ID Prefix F	F0278	Correction	ID Prefix	F0280		Correction
Reg. #	483.20(b)(2)(ii)	Completed	Reg. #	83.20(g) - (j)	Completed	Reg. #	483.20(d)(3), 483. (2)	10(k)	Completed
LSC		04/15/2016	LSC		04/15/2016	LSC			04/15/2016
ID Prefix	F0282	Correction	ID Prefix F	-0309	Correction	ID Prefix	F0312		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	83.25	Completed	Reg. #	483.25(a)(3)		Completed
LSC		04/15/2016	LSC		04/15/2016	LSC			04/15/2016
ID Prefix		Correction	ID Prefix F	F0431	Correction	ID Prefix			Correction
Reg. #	483.25(c)	Completed	Reg. #	83.60(b), (d), (e)	Completed	Reg. #			Completed
LSC		04/15/2016	LSC		04/15/2016	LSC			
ID Prefix		Correction	ID Prefix _		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC _			LSC			
REVIEWE STATE AC		REVIEWED BY (INITIALS) KS/kfd	DATE 05/02/201	SIGNATURE OF	SURVEYOR 0304	8		DATE 4/2	28/2016
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW 3/10/201		Y COMPLETED ON		K FOR ANY UNCORRECTED DEFICIENCI				☐ YE	s 🗆 no



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

April 29, 2016

Ms. Theresa Pridel, Administrator Golden LivingCenter - Slayton 2957 Redwood Avenue South Slayton, MN 56172

Re: Reinspection Results - Project Number S5386026

Dear Ms. Pridel:

On April 28, 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 April 28, 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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		1	DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00915 _{Y1}	B. Wing	Y2	2	4/28/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - SL	AYTON	2957 REDWOOD AVENUE SOUTH			
		SLAYTON, MN 56172			
This report is completed by a S	tata surveyor to show those deficiencies o	reviewely reported that have been corrected an	-d +i	ho data such	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix 2	20265		Correction	ID Prefix	20555		Correction	ID Prefix	20565		Correction
Reg. #	1N Rule 4658.0	085	Completed	Reg. #	MN Ru Subp.	le 4658.0405 1	Completed	Reg. #	MN Rule 4658.0 Subp. 3	405	Completed
LSC			04/15/2016	LSC			04/15/2016	LSC			04/15/2016
ID Prefix 2	20570		Correction	ID Prefix	20830		Correction	ID Prefix	20860		Correction
	MN Rule 4658.0)405	Completed	Reg. #	MN Ru Subp.	le 4658.0520	Completed	Reg. #	MN Rule 4658.0 Subp. 2 F.	520	- Completed
LSC _			04/15/2016	LSC	<u></u>	•	04/15/2016	LSC			04/15/2016
ID Prefix 2	20000		Correction	ID Prefix	21426		Correction	ID Prefix	21620		Correction
	1N Rule 4658.0)525	Completed	Reg. #	MN St.	Statute 144A.04	Completed	Reg. #	MN Rule 4658.1	345	Completed
LSC _	Subp. 3		04/15/2016	LSC	Subd.	3	04/15/2016	LSC			04/15/2016
ID Prefix 2	24000		0	ID Prefix	04005		0	ID Prefix			0
	IN St. Statute (626.557	Correction			Statute 626.557	Correction				Correction
Reg. # S	Subd. 3		Completed	Reg. #	Subd.		Completed	Reg. #			Completed
LSC _			04/15/2016	LSC			04/15/2016	LSC			-
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC _				LSC			-	LSC			-
REVIEWED	N BV	REVIEW	/ED DV	DATE		SIGNATURE OF	CUDVEVOD			DATE	
STATE AGE		(INITIAL		5/2/201	6	SIGNATURE OF		3048			8/2016
REVIEWED CMS RO	В В У	REVIEW (INITIAL	/ED BY	DATE		TITLE				DATE	
FOLLOWU 3/10/2016	P TO SURVE	COMPL	ETED ON			L R ANY UNCORRE CTED DEFICIENCI				F YE	s □ no

Page 1 of 1 EVENT ID: 7D8B12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 7D8B

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I	- TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00915
MEDICARE/MEDICAID PROVIDER NO.(L1) 245386 OTHER MENDO OF AMERICA ID NO.	3. NAME AND AD (L3) GOLDEN L 3 (L4) 2957 REDW	IVINGCENTI	ER - SLAY		4. TYPE OF ACT	2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L2) 660385800	(L5) SLAYTON,			(L6) 56172	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006	7. PROVIDER/SU 01 Hospital	IPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Af	
6. DATE OF SURVEY 03/10/2016 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENI 12/31	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 55 (L18) 13.Total Certified Beds 55 (L17)	Compliance1. As X B. Not in Com	equirements e Based On:	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: * Code:	6. Scope of 7. Medical I	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 55	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLIC	(L42) ABLE SHOW LTC CA	(L43)	DATE):			
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY AGENCY	/ APPROVAL	Date:
Joseph Garvey, HFE NE II	0	4/05/2016	(L19)	K <u>amala Fiske-Downing, Hea</u>	alth Program Repres	entative 04/28/2016 (L20)
PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		IPLIANCE WITI ITS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Control3. Both of the Above	ol Interest Disclosure Str	
22. ORIGINAL DATE 23. LTC AGRED OF PARTICIPATION BEGINNIN 12/01/1986 (L24) (L41)		4. LTC AGREEN ENDING DA		26. TERMINATION ACTION VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	<u>INVOLU</u> 05-Fail t	(L30) JNTARY o Meet Health/Safety o Meet Agreement
A. Suspensi	TVE SANCTIONS on of Admissions: Suspension Date:	(L44) (L45)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	der Status Change
28. TERMINATION DATE:	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
(L28)	00454		(L31)			
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION	OF APPROVAL	L DATE (L33)	DETERMINATION APP	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

March 25, 2016

Ms. Theresa Pridel, Administrator Golden LivingCenter - Slayton 2957 Redwood Avenue South Slayton, MN 56172

RE: Project Number S5386026

Dear Ms. Pridel:

On March 10, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

Golden LivingCenter - Slayton March 25, 2016 Page 2

(those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258

Email: Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level J deficiency (isolated deficiencies that constituted immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on July 17, 2015. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective March 30, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiencies cited at F157, F309, and F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 June 10, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

Golden LivingCenter - Slayton March 25, 2016 Page 4

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 September 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 04/05/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				TE SURVEY MPLETED	
		245386	B. WING			03/	10/2016	
	PROVIDER OR SUPPLIER	AYTON		29	TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	as your allegation of Department's accepenrolled in ePOC, y	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567	F C	000				
F 157 SS=G	form. Your electror be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with	F 1	57			4/15/16	
	consult with the resknown, notify the resor an interested fan accident involving tinjury and has the pintervention; a signiphysical, mental, or deterioration in heastatus in either life tolinical complication significantly (i.e., a existing form of treaconsequences, or totreatment); or a decite the resident from the §483.12(a).	ediately inform the resident; ident's physician; and if esident's legal representative mily member when there is an the resident which results in estential for requiring physician ficant change in the resident's a psychosocial status (i.e., a lith, mental, or psychosocial chreatening conditions or eas); a need to alter treatment eneed to discontinue an eatment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in						
ADODATOD		member when there is a	LATURE		TITI F		(X6) DATE	

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

02/20/2016

Electronically Signed

03/30/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE S COMPLE	
		245386	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	_AYTON	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	specified in §483.7 resident rights under regulations as specithis section. The facility must rethe address and phegal representative. This REQUIREMED by: Based on interview facility failed to notified to interview facility failed to notified the phegal representation of the for hospitalization of the changes in her resided and a congested tipply sician notification prescribed antibiotic respiratory infection an inpatient facility. Findings include: When interviewed telephone, R2's far questioned about many significant change health or status occoncern that R2 has prescribed by her pago". F-A stated shomitted medication when R2 required in the status occoncern that R2 has prescribed by her pago". F-A stated shomitted medication when R2 required in the status occoncern that R2 has prescribed by her pago". F-A stated shomitted medication when R2 required in the status occoncern that R2 has prescribed by her pago". F-A stated shomitted medication when R2 required in the status occoncern that R2 has prescribed by her pago". F-A stated shomitted medication when R2 required in the status occoncern that R2 has prescribed by her pago". F-A stated shomitted medication when R2 required in the status occoncern that R2 has prescribed by her pago".	roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's er or interested family member. NT is not met as evidenced and document review, the fixe family and physician in a confusion of 1 resident (R2) reviewed who experienced significant piratory condition requiring. This resulted in actual harm enced diminished lung sounds goth cough related to delayed on regarding failure to initiate confusion member (F)-A was not interesident's physical curred. F-A stated she had a confusion in the resident's physical curred. F-A stated she had a confusion," about two weeks the was not informed of the often that if the cospitalization due to the co	F 157	Golden LivingCenter Slayton realiz promoting care for residents in a tin manner to ensure proper treatment changes of conditions or cares. Staff have been educated on: -Golden LivingCenter Slayton's poliprocedure for timely contacting fam and physician with changes in condicares. -On-call physician lists have been obtained by collaborating with the comanager to have notification of who call, and licensed staff is educated utilization of on-call physician service. -On admission of residents, it is polattempt to identify reactions to medications listed as allergies. -The proper procedure for obtaining antibiotics and the timely administration antibiotics.	cy and ilies lition or linic or is on on ces.	

	OF DEFICIENCIES OF CORRECTION			E SURVEY PLETED			
		245386	B. WING			03/-	10/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - SL	AYTON		29	TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	treatment/medicatic felt this could have hospitalization for F primary family continuous were aware she she medical condition of F-A stated R2 had with respiratory contand that R2's health since this episode of physician had prese for R2's respiratory administered the maximum When interviewed of director of nursing prescribed Azithron respiratory infection stated that after the the pharmacy to be notified facility staff an allergy for R2. Informed the physician allergy symptoms, started on oxygen of saturation level me [diagnosis: upper rewas no further docurecord related to the 2/19/16, when the I assessment of R2 physician the follow thick yellow sputurn little or no air flow, addition, the fax incomplete in the second relation in the follow thick yellow sputurn little or no air flow, addition, the fax incomplete in the second relation in the follow thick yellow sputurn little or no air flow, addition, the fax incomplete in the second relation in the follow thick yellow sputurn little or no air flow, addition, the fax incomplete in the second relation in the follow thick yellow sputurn little or no air flow, addition, the fax incomplete in the second relation in the fax incomplete in the second relation for t	acted by the facility when the on had been prescribed, she potentially prevented R2. F-A stated she was the act for R2, and the facility staff ould be contacted regarding changes R2 might experience. been admitted to the hospital neerns, shortness of breath had continued to decline of illness. F-A stated the cribed Azithromycin (antibiotic) issues but the facility had not redication as ordered. On 3/8/16 at 12:48 p.m., the (DON) confirmed R2 had been nycin to treat an upper no (URI) [2/17/16]. The DON rescription had been sent to be filled, the pharmacy had the medication was listed as The DON stated the staff had been who had responded to the ndicating the medication was been and for staff to monitor for The DON stated R2 was on 2/17/16, due to her oxygen assuring 70% on room air respiratory infection]. There umentation in the medical re use of the Azithromycin until DON conducted a physical and subsequently faxed to the pring: R2 had "a hoarse voice, and very diminished, with middle lung lobes." In dicated R2 had a "tight and oxygen saturation measure	F 1	57	Random audits will be completed bi-monthly until July 1st with deficit practices brought to QAPI.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		` '	SURVEY PLETED
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, 2957 REDWOOD AVENUE SOU SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPR	BE	(X5) COMPLETION DATE
F 157	oxygen saturation in oxygen. In addition, had not been admir In response, R2's padmitted directly to transport. During in DON stated F-A hamorning of 2/19/16, about R2's condition family was first madereceived the physic time. The DON stated getting the medicat with the pharmacy. When interviewed to physician recalled the 2/16/16 or 2/17/16. Azithromycin for R2 physician confirmed with administering the monitor for any allestated he'd heard in when F-A contacted antibiotic had not be stated after F-A had staff had contacted been assessed with sputum, and diministering prescribed the physician furth having prescribed the as an outpatient, and adminishad attributed to R2 five days to treat here	The fax indicated R2's improved to 90-91% when on the fax identified the antibiotic histered as ordered 2/17/16. Thysician ordered that R2 be the hospital via ambulance terview with the DON, the dibeen at the facility on the and had expressed concerning. The DON verified that R2's de aware that R2 had not ian ordered antibiotic at that red, "the ball was dropped" on ion for R2 and being persistent on 3/8/16, at 1:32 p.m. R2's the facility faxing him on either asking about administering the respiratory symptoms. The dihe'd ordered staff to proceed the medication and for staff to rgy symptoms. The physician othing further until 2/19/16 did him to inform him the reen started. The physician of contacted him, the facility him to inform him R2 had in hoarseness, thick yellow shed to no air flow mid lobes. The antibiotic was to treat R2 and the facility's failure to ster the prescribed antibiotics of requiring hospitalization for the respiratory symptoms.	F 1	57			

	OF DEFICIENCIES OF CORRECTION			TE SURVEY MPLETED		
		245386	B. WING _		03	/10/2016
	PROVIDER OR SUPPLIER	LAYTON		STREET ADDRESS, CITY, STATE, ZIP O 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 157	room and noted rewheeze heard. 2+ 6 Resident has frequently when lying down. Fepisodes with eder signs) obtained and stethoscope and note left lobes sounded feeling ill. Fax send daughter to be notifacility." On 2/13/16 at 5:29 nurse tor report [R2 not transferring we family had also repough. The docum "Residents condition has been more difficated left. Frequent cough (doctor) on call at houneb's q (every) for Prednisone 60 today and tomorrow Monday" An undated note do the progress notes returned from seein were for Azithromy mg daily x 4 days. pharmacy). They residnet had an allocheck with Doctor.	o p.m., "This nurse went into sident lying in bed audible edema noted to bilateral feet. ent non productive cough Resident has had frequent ma to bilateral feetVS (vital d lung sounds listened to per oise noted in right lobes where diminished. Resident denies to MD (medical doctor) and fied when she comes in p.m., family approached this 2] was not waking up today and II. The note indicated the orted R2 had a frequent nented note included, on has changed this week. She icult to transfer and has had at and more cough Lung in right and sounds noted in h noted. Call placed to Dr. nospital and order received for 4 hours prn (as needed) and mg (milligrams) po (orally) w and to check with Dr on coumented on the back side of included, "On 2/16, resident ng Drat clinic. New orders cin 500 mg first dose then 250 Order was sent to (name of returned the order stating ergy to this medicine & double Resent to Dr& returned itro for reaction. This was	F 15	7		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 157	Thursday morning (see what was happ I sent it last night, w fax it again, with the out on that evening cart to be put in MA record) once the me E-kit (emergency ma supply of this med 250 mg in stock." On 2/17/16 at 5:37 C-Pap per self throsaturation @ (at) 4: air). Applied PRN o L.(liters) Neb (nebu Oxygen increased this time 98% with a cough of points of points of points of points of points and included to visit today, has considered r/t allergy of daughter discovere intolerance not a truth am (morning) a 2/18/16. Pt has a hough, very dm (dir mid lobe down nor clear. Resident sats oxygen. Resident fr	ne of pharmacy). On (name of pharmacy) calls to ening with order. I stated that where upon she asked me to e promise that it would be sent run. Order was left on med and (medication administration edicine arrived. The EDU redication kit) was checked for d, & had only had one pill of a.m., "Resident removed ughout night. Oxygen 30 a.m. was 70% RA (room xygen via nasal cannula @ 4 lizer) treatment completed. o 96%. Oxygen saturation at 4 L oxygen."	F1	57			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG	COMPLETED			
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER	_AYTON		STREET ADDRESS, CITY, S 2957 REDWOOD AVENU SLAYTON, MN 56172	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULE CED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
F 157	dyspnea and denie Appears ill looking. Drwith above infonotified." On 2/19/16, at 11:5 daughter about fax sounds, low grade oxygen on. Discuss breath) at this time have pneumonia di would need to see wants to just see heresident can be seemind. Call placed to of allergy. On 2/19/16, at 2:24"1330 (1:30 p.m.) Note admit to hospital in agreement- Fax ambulance. Ambute tresident transfer During interview on practical nurse (LP) the message from allergy to Azithromy physician related to During review of R2 verified LPN-A had 2/16/16 to inform the allergy. However, the clinic after hours with the control of the co	Temp 99.9 Fax sent to (information) and daughter (information) and resident not leaving sed she is not sob (short of information). Daughter asked if she may scussed it is possible but a doctor to determine this. She to the control of the changes here in the control of the changes here in the control of the changes here in the control of the case (information) and the control of the resident's the fax had been sent to the hile the clinic was not open,		57			
	2/17/16 at approximate documented in the	response to the fax until mately 4:00 p.m. as progress notes. LPN-A stated o the clinic versus an on-call					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/-	10/2016
	PROVIDER OR SUPPLIER	AYTON		2957	EET ADDRESS, CITY, STATE, ZIP CODE 7 REDWOOD AVENUE SOUTH AYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	physicians did not liconcerns when it w further clarified she the fax to an on-cal was aware the physithe fax until the following the fax until the fax until the fax until the following the fax until the fax until the fax until the following the fax until the fax until the fax until the fax until the following the fax until the fax until the following the fax until the following the fax until the fax until the following the fax until the fax until the following the fax until the fax until the fax until the fax until the following the fax until the fax until the following the fax until the following the fax until the fax until the following the fax until the following the fax until the following the fax until the fax until the fax until the fax until the following the fax until the fax until the following the fax until the fax unti	had been her experience," like to deal with patient as not their patient." LPN-A had not considered sending I physician. LPN-A stated she sician would probably not get owing day. on 3/8/16, at 1:47 p.m. the not stated the facility should physician to identify whether a nowled be appropriate as the outtypically contact the remacy consultant stated the questioned the use of an ion and should have had the pharmacy an order to indicate ead and use the Azithromycin, would have filled the	F 1	57			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING _		08	3/10/2016
	PROVIDER OR SUPPLIER	_AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	LPN-B stated she is about the Azithrom morning [2/13/16] anot an allergy but a The facility's policy Resident Health Stidentified the facility resident's physician physician assistant A. An accident occand required poten B. Acute illness or resident's physical, status (i.e. deterior psychosocial status conditions or clinical C. A need to alter the need to discontinued due to adverse connew form of treatm assessment approximmediate (defined no longer than 24 hr D. A decision to transplant to the prescrib pharmacy declined the physician to inform alert to the prescrib pharmacy declined the physician. The clinical the fax was sent, the antibiotic to treat R staff finally received	recalled having asked F-A ycin allergy for R2 on Saturday and F-A identified there was in intolerance instead. Notification of Change in atus, revised 11/11/15, y would consult with the n, nurse practitioner or r, and family when: urred which resulted in injury tial for physician intervention. a significant change in the mental, or psychological ation in health, mental or in either life threatening al complications. The reatment significantly (i.e. a eran existing form of treatment is equences, or to commence a ent. Depending on nursing priate notification may be a in policy as soon as possible mours) to 48 hours.	F 15	57		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER	AYTON		29	FREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	additional two days declining respirator antibiotic had been	not administered for an . R2 was hospitalized due to a y status, URI, for which the originally ordered.	F 1				
F 225 SS=D	483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/IND	PORT	F 2	:25			4/15/16
	been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for	of employ individuals who have if abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a stan employee, which would or service as a nurse aide or of the State nurse aide registry ties.					
	involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a	isure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).					
	violations are thoro	evidence that all alleged ughly investigated, and must ential abuse while the rogress.					
	to the administrator representative and	vestigations must be reported or his designated to other officials in accordance uding to the State survey and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		` '	E SURVEY PLETED
		245386	B. WING		_	03/	10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STA 2957 REDWOOD AVENUE S SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 225	incident, and if the appropriate correct This REQUIREMENT by: Based on interview facility failed to immadministrator and Salleged violation of (R2) for whom an areviewed. Findings include: When interviewed of telephone, R2's fand had a concern that medication prescribe two weeks ago". Fof the omitted medicater when R2 requirespiratory difficulties he had been contained treatment/medication for Formary family contained were aware she she medical condition of) within 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced and document review, the	F 2		Slayton realized diate reporting to the administed dure for immed legations has lated at the state of the sta	of trator diate peen ided to I State make make ouse he ED /	
	and that R2's health since this episode of physician had preso for R2's respiratory	cerns, shortness of breath had continued to decline of illness. F-A stated the cribed Azithromycin (antibiotic) issues but the facility had not edication as ordered.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD IE APPROPR	BE	(X5) COMPLETION DATE
F 225	director of nursing (prescribed Azithrom respiratory infection stated that after the the pharmacy to be notified facility staff an allergy for R2. Tinformed the physic pharmacy alert by it still to be administe allergy symptoms. Started on oxygen of saturation level measuration level measuration level measuration level measuration until 2 conducted a physic subsequently faxed R2 had "a hoarse very diminished, with lung lobes." In add a "tight congested of measure 87% on round R2's oxygen saturation oxygen. In additionation and the 2/17/16. In response R2 be admitted directly ambulance transpound DON, the DON also facility on the morning expressed concerning DON verified that Raware that R2 had ordered antibiotic as	on 3/8/16 at 12:48 p.m., the DON) confirmed R2 had been export to treat an upper (URI) [2/17/16]. The DON prescription had been sent to filled, the pharmacy had the medication was listed as the DON stated the staff had ian who had responded to the endicating the medication was red, and for staff to monitor for The DON stated R2 was on 2/17/16, due to her oxygen assuring 70% on room air espiratory infection]. However, or assessment documentation or drelated to the use of the endication the physician the following: oice, thick yellow sputum and the little or no air flow, middle into, the fax indicated R2 had cough and oxygen saturation from air." The fax indicated the endicated the endicated to the hospital via endicated F-A had been at the endicated F-A had been at the endicated F-A had been at the endicated first been made about R2's condition. The 2's family had first been made not received the physician that time. The DON stated, ed" on getting the medication endication getting the medication endication that time. The DON stated, ed" on getting the medication	F 2	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/10/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 2957 REDWOOD AVENUE SOUT SLAYTON, MN 56172		99,19,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATI	(X5) COMPLETION DATE
F 225	for R2 and being p When interviewed physician recalled 2/16/16 or 2/17/16 Azithromycin for R physician confirme with administering monitor for any alle stated he'd heard when F-A contacted antibiotic had not be stated after F-A has taff had contacted been assessed with sputum, and dimin The physician furth having prescribed as an outpatient, a acquire and admin had attributed to R five days to treat h During review of R verified a fax had be 2/16/16 to inform thowever, the fax when the clinic waresponse to the fax approximately 4:00 progress notes. When interviewed DON stated this is the State agency a accordance with the During interview were purposed to the fax approximately 4:00 progress notes.	on 3/8/16, at 1:32 p.m. R2's the facility faxing him on either asking about administering the 2's respiratory symptoms. The ed he'd ordered staff to proceed the medication and for staff to ergy symptoms. The physician nothing further until 2/19/16 and him to inform him the even started. The physician d contacted him, the facility d him to inform him R2 had the hoarseness, thick yellow ished to no air flow mid lobes. Her stated the rationale for the antibiotic was to treat R2 and the facility's failure to ister the prescribed antibiotics 2 requiring hospitalization for er respiratory symptoms. 2's medical record it was been sent to the clinic on the physician of the allergy. Was sent to the clinic after hours and not pen thus there was no a until 2/17/16 at 10 p.m. as documented in the sue had not been reported to and/or the administrator in	F 2	225		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		l i de la companya d	(X3) DATE SURVEY COMPLETED	
		245386	B. WING _		03/10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From pa	_	F 22	5	
	provider because it physicians did not li concerns when it w stated she did not con-call physician. L	the clinic versus an on-call had been her experience," like to deal with patient as not their patient." LPN-A consider sending the fax to an PN-A stated she was aware I probably not get the fax until			
F 226 SS=D	Adult Maltreatment identified neglect as supply a resident woneeded to obtain an health and safety. It care or services to anguish, or mental neglect and medica administrator and a The policy identified be reported immed administrator/direct entry point, and Statof Health. 483.13(c) DEVELO ABUSE/NEGLECT	or of nursing (DNS), common te of Minnesota Department P/IMPLMENT , ETC POLICIES evelop and implement written	F 22	6	4/15/16
	and misappropriation This REQUIREMENT by:	ect, and abuse of residents on of resident property. NT is not met as evidenced			
		and document review, the lement their Abuse/Neglect		F226 Golden LivingCenter Slayton realizes	the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245386	B. WING		····	03/-	10/2016
	PROVIDER OR SUPPLIER	LAYTON		29	TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	policy to ensure imallegations of potes State Agency (SA) reviewed. Findings include: The facility's Abuse Adult Maltreatment identified neglect a supply a resident wine eded to obtain a health and safety. care or services to anguish, or mental neglect and medica administrator and a The policy identifies be reported immediadministrator/direct entry point, and State of Health. When interviewed telephone, R2's far had a concern that medication prescrit two weeks ago". For the omitted mediater when R2 requirespiratory difficulties the had been continued the pospitalization for I primary family continued were aware she she medical condition of the primary family continued in the same and the same an	mediate reporting of ntial neglect of treatment to the for 1 of 3 residents (R2) e /Neglect policy, Vulnerable Plan updated 1/2016, s "a failure or omission to with care or services that are nd/or maintain the resident's It includes failure to provide avoid physical harm, mental illness." The policy identified al errors as reportable to the appropriate state agencies. d allegations of neglect should	F 2	226	importance of immediate reporting allegations of abuse to the administ and State agency. The policy and procedure for immereporting of abuse allegations has breviewed for resident #R2. To prevent further incident to other residents, re-education will be provistaff on timely reporting of abuse allegations to the administrator and agency and on performing a comprehensive investigation. To monitor its performance and to resure solutions are sustained, rando audits on immediate reporting of abuse allegations and the comprehensive investigation will be performed by the Designee until July 1st with audit reserviewed in QAPI quarterly as need.	diate peen dided to I State make puse the ED / esults	

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F 226	with respiratory cor and that R2's health since this episode ophysician had press for R2's respiratory administered the manual with the pharmacy infection stated that after the the pharmacy to be notified facility staff an allergy for R2. Informed the physic pharmacy alert by is still to be administe allergy symptoms. Started on oxygen of saturation level me [diagnosis: upper return the medical reconducted a physic subsequently faxed R2 had "a hoarse wery diminished, willing lobes." In addit a "tight congested of measure 87% on re R2's oxygen saturation to 2/17/16. In responsible admitted direction and the physic subsequently faxed R2 had "a hoarse wery diminished, willing lobes." In addit a "tight congested of measure 87% on re R2's oxygen saturation oxygen. In addit antibiotic had not be 2/17/16. In responsible admitted direction and the physical state of the physic	age 15 Incerns, shortness of breath had continued to decline of illness. F-A stated the cribed Azithromycin (antibiotic) issues but the facility had not redication as ordered. In 3/8/16 at 12:48 p.m., the (DON) confirmed R2 had been redication to treat an upper in (URI) [2/17/16]. The DON is prescription had been sent to be filled, the pharmacy had the medication was listed as the DON stated the staff had been who had responded to the indicating the medication was bred, and for staff to monitor for the DON stated R2 was on 2/17/16, due to her oxygen assuring 70% on room air respiratory infection]. However, or assessment documentation ard related to the use of the 2/19/16, when the DON real assessment of R2 and it to the physician the following: roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow, middle roice, thick yellow sputum and the little or no air flow yellow sputum and the little or no air flow yellow sputum and the little or no air flow yellow sputum and the little or no air flow yellow sputum and the little or no air flow yellow sputum and	F 2	26			

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F 226	expressed concern DON verified that Raware that R2 had ordered antibiotic a "the ball was dropp for R2 and being per When interviewed ophysician recalled to 2/16/16 or 2/17/16 and Azithromycin for R2 physician confirmed with administering the monitor for any allestated he'd heard not be stated after F-A had staff had contacted been assessed with sputum, and diminister that an outpatient, an acquire and administer that an outpatient, are acquire and administer that a san outpatient, are acquire and administer to days to treat her During review of R2 verified a fax had be 2/16/16 to inform the However, the fax we when the clinic was response to the fax approximately 4:00 progress notes.	about R2's condition. The about R2's condition. The about R2's condition. The about R2's family had first been made not received the physician at that time. The DON stated, and on getting the medication existent with the pharmacy. On 3/8/16, at 1:32 p.m. R2's the facility faxing him on either asking about administering the about a head and a horizon and for staff to a contacted him, the facility him to inform him the about a contacted him, the facility him to inform him R2 had a hoarseness, thick yellow shed to no air flow mid lobes. For stated the rationale for the antibiotic was to treat R2 and the facility's failure to a ster the prescribed antibiotics are respiratory symptoms. On a service of the allergy are sent to the clinic after hours and open thus there was no	F 2	26			

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F 226	DON stated this iss the State agency ar accordance with the During interview wit (LPN)-A on 3/8/16, she sent the fax to provider because it physicians did not li concerns when it w stated she did not con-call physician. L	ue had not been reported to nd/or the administrator in	F2	26		
F 274 SS=D	AFTER SIGNIFICA A facility must cond assessment of a re facility determines, that there has been resident's physical of purpose of this sec	MPREHENSIVE ASSESS NT CHANGE uct a comprehensive sident within 14 days after the or should have determined, a significant change in the or mental condition. (For tion, a significant change line or improvement in the	F 2	74		4/15/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 274	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 274	F274 Golden LivingCenter Slayton realizes importance of updating care plans to reflect our resident's treatments and cares. #R5's care plan has been reviewed a revised as related to pressure ulcer integrity and is receiving care per caplan. R5's Comprehensive Assessmas been updated to reflect the residurrent status. A wound packet to include a list with needed care plan changes has been implemented and will be compiled by licensed staff. Licenesed staff will up the care plan with this information. IDT (Intradisciplinary Team) will reviewound flow sheets and would care peducation on the UDA Policy is included.	and / skin re nent dent's n y pdate The ew olans. ided	
	assessments, R5 h on the buttocks dat physician note date Tagaderm applicati	view of the weekly skin and a an open area identified ed 2/2/16. According to the ed 2/5/16, he ordered a foam on to the "sacral wound" every e no measurements nor		as a hard copy in the wound packet. Weekly wound audits including week UDA Policy and wound flow sheet / significate change education is giver the nurses. Ongoing education will b given.	kly n to	

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F 274	Continued From page 19 assessments completed to indicate that R5 had developed an open pressure ulcer on 2/1/16. The hospital discharge summary indicated R5 had a Stage II pressure ulcer on the coccyx when admitted and had not healed when discharged on 2/11/16. The open area was present at the time of the reassessment, yet no comprehensive assessment was performed and/or documented at the time of the significant change Minimum Data Set (MDS) dated 2/18/16. The assessment indicated R5 required extensive assistance with bed mobility and transferring. The significant change MDS dated 2/18/16, did not indicate the presence of any pressure ulcer (0); no evidence of skin breakdown. The associated Care Area Assessment (CAA) indicated R5 was at risk for developing pressure ulcers but no further analysis of the open wound on the coccyx was documented.		F 2	Audits will be done randomly bimo		
F 278 SS=D	director of nursing (assessment proces per facility protocol. The Weekly Skin R directs skin alteration the figures provided and location. It furth flow was to be initia 483.20(g) - (j) ASSI ACCURACY/COOF The assessment m resident's status.	eview policy dated 5/1/15 on findings to be identified, use d, describe type of alteration ner directs a wound evaluation tted/updated. ESSMENT RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate	F 2'	78		4/15/16

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F 278	Continued From page 20 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. Clinical disagreement does not constitute a material and false statement.		F 2	78		
	by: Based on observa interview facility fai Minimum Data Set residents (R40) rev Findings include: On 3/7/16, at 12:0 have broken and m A physician pre-opidentified: "Teeth ai need of repair. Ma	tion, document review and led to accurately code the (MDS) assessment for 1 of 3 viewed for dental services. 9 p.m. R40 was observed to hissing upper and lower teeth. erative note dated 5/11/15, and gums however are in grave my other teeth are broken off, a see that appears to be of		F278 Golden LivingCenter Slatimportance of timely assisted residents. Resident #5 has been reprevent other residents facility has re-educated a RNAC on the comprehe according to the RAI mature solutions are sustain	essments of its eassessed. To from incidents, the and retrained the ensive assessments nual. from incidents, the and retrained the from incidents incidents and incident	

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F 280 SS=D	teeth are broken of to the accident or p not have data regard dated 12/15/15, ide several missing (no some remaining tee dentition chronic); a not interested in a comprehensive comprehensive as determined to the dentity any dental problems" even the broken/missing tee. During interview with 3/8/16, at 2:04 p.m. change MDS dated broken, carious tee been identified on the 483.20(d)(3), 483.1 PARTICIPATE PLA. The resident has the incompetent or other incapacitated under participate in plannic changes in care and a comprehensive assinterdisciplinary teaphysician, a register for the resident, and disciplines as determined as a comprehensive as a	s; however, again many of the f, whether part of this is related oor dental hygiene prior, I do rding same". A nursing noted ntified R40 had own teeth with partial for missing dentition); eth broken and carious (poor and resident stated she was dental consult. Eview it was noted the MDS dated 12/15/15, did not problems. It documented "no hugh R40 had many th. Ith the MDS coordinator on it was verified the significant 12/15/15, did not identify the th and stated this should have the MDS. O(k)(2) RIGHT TO NNING CARE-REVISE CP the right, unless adjudged the erwise found to be the laws of the State, to lang care and treatment or	F 28	audits will be performed bimonthly ED / Designee until July 1st with a results reviewed in QAPI quarterly needed.	udit	4/15/16

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F 280	legal representative	age 22 sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 28	30			
	by: Based on observareview the facility fareview ulcers. Findings include: During observation 1:54 p.m. R5 was owith her right ear result was observed to be both her feet restin protector on nor feet was observed R5's scabbed area. At the noted a sore on he on 12/11/15. R5 fureview of the week indicated R5 was idear (no measurement was observed R5's scabbed area. At the noted a sore on he on 12/11/15. R5 fureview of the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the week indicated R5 was idear (no measurement was observed R5's action to the was observed R5's action to the was observed R5's action to the was observed R5's action	tions, interview and document ailed to revise the plan of care (R5) who was reviewed for as of positioning on 3/8/16, at observed lying on her right side esting on the bed pillow. On on 3/9/16, at 7:12 p.m. R5 is sleeping in her recliner with g on the foot rest; without heel et elevated on a pillow. On on 3/9/16, at 1:07 p.m. it is outer right ear had a bloody nat time, R5 indicated she ir right ear prior to admission of the revealed she obtained the er oxygen tubing. Rely skin review dated 3/1/16, dentified with a reddened right earts). Review of the wound 3/16, identified right ear oo.5 cm length and 1.0 cm		F280 Resident #5 care plans have be reviewed and revised as indicatorisk for pressure ulcer / skin and is receiving care per care. Residents, identified with pressure plans and CNA sheets has reviewed and revised as indicated receiving cares per care plan. Nursing staff and CNAs will be to provide cares in compliance identified interventions in the replan. Random bimonthly audits will be conducted by DNS / Designee appropriate cares have been of conjunction with identified care interventions. Audits will be prequent.	ated related integrity plan. sure ulcers, ave been ated and are educated with esident care to ensure completed in e plan		

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F 280	pillow. Review of the 2/23/16, R5 was idented to the right heel. Redated 3/3/16, identition be 2.0 cm length	ge 23 e weekly skin review dated entified with a pressure ulcer eview of the wound evaluation fied the left heel measurement by 2.5 cm width with an eluded a heel protector to the	F 28	30		
	1/1/16 identified R5 alteration in skin int interventions includ and pressure reliev assist with pericare post]dribbling/incon quarterly, (4) encoureport signs of skin assessment weekly (8) treatment to alter	tinence, (3) Braden scale urage fluids (5) monitor and breakdown (6) skin (7) tissue tolerance testing ered skin site per M.D. order. at included a neck pillow or a				
F 282 SS=D	director of nursing (had not been revise related to R5's presand left heel; which right ear and heel p	on 3/09/2016, at 7:04 p.m. (DON) verified the care planed to include interventions sure ulcers to the right ear included a neck pillow to the rotector to the left heel. RVICES BY QUALIFIED ARE PLAN	F 28	32		4/15/16
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of				
	This REQUIREMEN	NT is not met as evidenced				

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F 282	review the facility fa for 2 of 4 residents identified at risk for and had facility acc 1 of 3 residents (Rassistance with grows Findings include: R43 was admitted listed on his active anemia, depression repeated falls and lelected hospice sets tage liver cirrhosis. When interviewed registered nurse (Fhad a Stage III presegion which had desident at the facil R43's care plan day concern with poten integrity related to a communication definited with a stall interventions included.	tion, interview and document ailed to follow the plan of care (R2, R5) reviewed who were pressure ulcer development quired pressure ulcers and for 1) reviewed who required for 2/15/16 family revices related to diagnosis end 3. 2) 13/7/16, at 10:39 a.m. the RN) case manager stated R43 saure ulcer on the sacral eveloped while R43 was a ity. 2) 2) 2) 3 a.m. the RN) case manager stated R43 saure ulcer on the sacral eveloped while R43 was a ity. 2) 3 a.m. the RN) case manager stated R43 saure ulcer on the sacral eveloped while R43 was a ity. 2) 4 c.	F 28	F282 Resident #43 and #1 care plans been reviewed and revised as in related to wound staging and dia cares. Wound flow sheets have reviewed and updated. Golden LivingCenter Slayton will wound education to all licensed scomplete accurate skin assessm based on evaluation. Golden LivingCenter Slayton's standard provide necessary services to m grooming and personal hygiene. All diabetic nail care will be compassigned on the eTAR by license CNA staff will be educated on the clean and file diabetic residents well as general nail care on all re Nail audits will be completed ran and brought to QAPI. Residents identifed with pressure the care plans and CNA sheets he reviewed and revised as indicate receiving care per care plan. Nursing staff and CNAs will be e to provide cares in compliance widentified interventions in the resident(s) to ensur appropriate cares have been cor conjunction with the identified calinterventions and weekly assess	provide staff to ents s to aintain sletted as d staff. e ability to nails as sidents. domly e ulcers - lave been d and are ducated ith dent care e e npleted in re plan	

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F 282	6.) Monitor and rep. 7.) Provide pericar 8.) Skin assessme 9.) Tissue toleranc 10.) Treatment to a 11.) Turn/reposition 12.) Weekly decubing During observation nursing assistants (R43's room to reposition nursing assistants (R43's room to reposition nursing assistants (R43's room to reposition and the side by NA-I foam cover locate 2 x 4 non-stick dress NA-B and NA-C staunder each dressin aware of the character they were usually pwhile the nurse was wounds. NA-B indictionally with his declination and period to the side usually came in would get him up in the side of the side	e up & as active as possible; port signs of skin breakdown; e after incontinent episodes; nt weekly; e testing; ltered skin site per M.D. order; and/or off-load every hour; tus update; on 3/9/16, at 10:38 a.m. (NA)- B and NA-C entered	F 2	282	completed. Audits will be presente QAPI. DNS / Designee is the repoparty.		
	11:59 a.m. registered practical nurse (LPI) R43 was noted to hover his coccyx regabove the foam dreaming dressing was noted also noted to have his coccyx, a Stage	of wound cares on 3/9/16, at ed nurse (RN)-A and licensed N)-B performed wound cares. ave a large foam dressing ion and two 4 x 4 dressings essing on his sacrum region. directly above the foam I to have drainage. R43 was a quarter sized Stage II PU on a III PU of golf ball size					

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		245386	B. WING _		03	/10/2016	
	PROVIDER OR SUPPLIER	_AYTON		STREET ADDRESS, CITY, STATE, ZIP C 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		, 10, 2010	
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F 282	ulcer. RN-A cleans cleanser and re-ap R43's Minimum Da identified R43 with -admission assess (1) Stage I PU; -14 day assessmer Stage I PU; -30 day assessmer Stage I PU; -30 day assessmer Stage I PU; -3ignificant change identified (1) Stage The facility wound Flowsheet", initiate 11.5 centimeter (crupressure area on hevaluation dated thidentified R43 with measuring 1.0 cm. There was no document wounds up to the dwhen the progress pressure ulcers prievaluation forms. The facility identifies acrum on 3/9/16, cm. Weekly skin asses were incomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the wfollowing skin asse R43's medical recomplete or evaluation of the	e II pressure above the sacral sed each wound with wound plied dressings to the wounds. Ita Set (MDS) assessments the following pressure ulcers: ment dated 1/2/16, identified int dated 1/9/16, identified (1) int dated 1/9/16, identified (1) int dated 1/23/16, identified (1) int dated 1/23/16, identified (1) int dated 1/23/16, identified R43 with a manual second Evaluation dates 1/28/16, identified R43 with a manual second Stage I PU, interaction of the late of these evaluations even notes identified R43 had other for to the ones indicated on the late of these evaluations even notes identified R43 had other or to the ones indicated on the late of these evaluations even notes identified R43 had other or to the ones indicated on the late of these evaluations even notes identified R43 had other or to the ones indicated on the late of these evaluations even notes identified R43 had other or to the ones indicated on the late of these evaluations even notes identified R43 had other or to the ones indicated on the late of the evaluation of the late of these evaluations even notes identified R43 had other or to the ones indicated on the late of these evaluations even notes identified in the record inaccurate based on the hole medical record. The ssment were identified in	F 28	2			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING		03	/10/2016
	PROVIDER OR SUPPLIER N LIVINGCENTER - SI	LAYTON		STREET ADDRESS, CITY, STATE, ZIP C 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	coccyx with no des 2. 1/21/16 skin ass on coccyx but no d 3. 1/28/16 skin revid 4. 2/4/16 skin revid on coccyx. Multiple buttocks. Dressing: During interview wi (DON) on 3/9/16, as she was unaware to The DON stated shinconsistency in as lack of training of size related to pressure there were not weed decub monitoring, signs of skin break plan. On 3/9/16, at 3:20 consultant was interviewed and assess taff needed more On 3/9/16, at 4:10 was interviewed and dressing change slon R43's buttocks, approximately quand open area on sacra looking area, dime region. On 3/10/16, at 6:58 (LPN)-B was interviewed and complete the consultant was interviewed and consultant was in	cription of wounds. essment identified open areas etails of characteristics. ew identified skin intact. ew identified a large open area e open areas on bilateral is in place. th the director of nursing at 1:00 p.m. the DNS stated hat R43 had 3 pressure ulcers. he realized there was some sessing pressure ulcers due to ome of the licensed staff ulcers. The DON verified ekly skin assessments, daily or monitoring and reporting down as directed by the care p.m. the facility nurse erviewed and verified there out license staff's ability to ss pressure ulcers and stated	F 24	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/-	10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY 2957 REDWOOD AVEN SLAYTON, MN 5617	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD NCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	identified R43 had a larger sacral wound above the sacral arwhat was visualized observation on 3/9/ On 3/10/16, at 8:33 was interviewed and NA with R43 the prefoam dressing and his back above the On 3/10/16, at 9:18 room and measured identified with the form the coccyx wound in but a 1.8 cm. Sacral wou larger sacral wound above to measured 1 cm x 1 not aware of the su wounds. The periph been noted in any of the related to his long the development. The related to his long the development or det ulcers. On 3/7/16, at 11:11 R1 was observed in fingernails with dark	a wound on his coccyx, a l, and 1 a smaller wound ea which would correlate with during dressing change 16. a.m. nursing assistant (NA)-F d stated she had worked as a evious week and R43 had a two additional dressings on foam dressing. a.m. the DON entered R43's d R43 wounds. R43 was ollowing open areas. attocks crease measured 2 cm and on the periphery of the l measured 0.8 cm x 0.6 cm. the larger sacral wound cm. The DNS stated she was pra sacral or peripheral sacral heral sacral wound had not documentation. of R43's medical record it was t consistent tracking, accuracy bing monitoring of pressure 143 was identified at high risk history of pressure ulcer medical record failed to wounds or show continuous	F 2	82			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	On 3/09/16, at 4:16 in bed while in his is long, jagged finger present under the if fingernails were lor facility had a class where they soak the also file/trim and present under the in between and he whether he would a fingernails, R 1 reserview of R1's eT administration receincluded: "clean, to the 15th & 30th of morning every 14 of 3/1/16, identified an interventions included: "when interviewed nursing assistant (I responsible for triminity diabetic. NA-A concleaning R1's nails cooperative with as when interviewed director of nursing responsible for reserviewed in the side of the side	age 29 5 p.m. R1 was observed lying room and continued to have nails with brown residue nails. R1 confirmed his ng and soiled and stated the approximately once a week e nails to clean them and will ut polish on the nails. When if offer to clean his fingernails responded, "no." When asked allow staff to clean and trim his ponded affirmatively. AR (electronic treatment ord) dated March 2016 rim and file finger and toe nails every month. [sic] in the day(s)." The care plan dated in alteration in self care with ding: "assist with nail care". On 3/10/16, at 10:50 a.m. NA)-A stated the nurses were aming R1's nails as he is offirmed the NA's assist with in between and that R1 was esistance with ADL's. On 3/10/16, at 1:30 p.m. the (DON) confirmed NA's were ident nail care and that the ere responsible for trimming on verified the NA's should still ails and also could file R1's veyor and confirmed they were ON stated she would have so to be trimmed by nursing (trim on 15th and 30th of each	F 2	32		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER	AYTON		29	TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	month) and would hand file R1's nails a R5 was admitted or hospital stay for red side (fluid accumula diagnoses that inclu II), osteoarthritis, mattack) and heart fa R5's care plan initia was a potential for a plan and intervention bed and pressur (2) Assist with period (3) Braden scale question (5) monitor and reperoder. During an observation observation applied treatment to ulcer. The ulcer was centimeters (cm) be millimeters. The prehave rolled edges a large area of rednessible for she fell [2/7/assisted with persowas sore; they told R5 stated, "They we that's all they did. N	ave expected NA's to clean is needed per the plan of care. In 12/11/15, following a 9 day current pleural effusion on right ation in the lung). R5 has other ude diabetes mellitus II (DM yocardial infarction (heart illure. Inted on 1/1/16, indicated there alteration in skin integrity. The passion included: (1) air mattress are relieving pad in wheelchair, eare s/p dribbling/incontinence, earterly, (4) encourage fluids out signs of skin breakdown at weekly (7) tissue tolerance into altered skin site per M.D. Ition on 3/9/16, at 4:53 p.m. Ition on 3/9/	F 2	82			

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F 282	Documentation revassessments did neasurements to repart of the weekly sin the care plan. Deprogress notes dathaving a dark redd of buttocks which rethe area was tendebeen treated with side of buttocks appropriate of buttocks appropriate of buttocks approved serosanguing drainage), but no neasurements also noted the would dark center. R5 incomplete of the weeklindicated an open slowly but not measurements. The 3/1/16, indicated R (no measurements assessment dated on buttocks only, neasurements and a skin monitoring, this for R5's left buttock the wound had not indicate whether he	realed the weekly skin not include wound monitor progress/decline as skin assessments as identified rocumentation in the nursing red 1/22/16, identified R5 as ened blistered area on left side measured 4.0 cm by 2.0 cm, or to touch and had previously parrier cream. Progress notes cated blistered area on left opeared to have popped and neous drainage (watery bloody neasurement taken. Further a progress note for 2/27/16 g was changed on coccyx and increased in size and was surement. The documentation and had yellow edges with a dicated it hurt more lately. It was kin review dated 2/2/16, area on buttocks, healing sured. The weekly skin review cated areas on buttocks with patches with no ne weekly skin review dated 5 had open areas to coccyx ataken). The weekly skin 3/8/16, indicated open areas	F 28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 282		ge 32 ng and measurement of the ult to determine the status of	F 28	2		
F 309 SS=G	director of nursing ulcer on the left but appropriately meas measurements so t assessed.	on 3/10/16, at 8:15 a.m. the (DON) verified the pressure tock should have been ured and monitored, including he healing progress could be CARE/SERVICES FOR EING	F 309)		4/15/16
	provide the necessor maintain the high mental, and psychological provides the provides and provides the provi	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment				
	by: Based on interview facility failed to provand services for 1 c who had been hosp actual harm for R2, lung sounds, thick y congested cough reassessment, delayed physician, delayed treatment and subsfacility due to respir the facility failed to	NT is not met as evidenced and document review, the vide adequate nursing care of 1 resident (R2) reviewed obtalized. This resulted in who experienced diminished vellow sputum and a tight elated to delayed nursing ed notification of the family and administration of antibiotic equent transfer to an inpatient atory difficulties. In addition, consistently assess and no of pain for 1 of 3 residents of experienced pain.		F309 Golden LivingCenter Slayton realized improtance to promote care for resin a timely manner to ensure proper treatment in changes of condition. All residents have the potential to be affected. Resident #2 primary care physician was notifed at time of errodiscovery and medication was give order. To prevent further incident, staff has been educated on:	idents er pe e or or n per	

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F 309	Continued From p	age 33	F 309			
	telephone, R2's fa questioned about significant change health or status or concern that R2 h prescribed by her ago". F-A stated s omitted medication when R2 required respiratory difficult she had been contreatment/medicate felt this could have hospitalization for primary family conwere aware she simedical condition F-A stated R2 had with respiratory cound that R2's heal since this episode physician had presfor R2's respirator administered the r	on 3/7/16, at 2:35 p.m. via mily member (F)-A was notification by staff when a in the resident's physical curred. F-A stated she had a ad not received a medication physician," about two weeks he was not informed of the n/treatment until 3 days later hospitalization due to ties. F-A further explained that if tacted by the facility when the ion had been prescribed, she expotentially prevented R2. F-A stated she was the stact for R2, and the facility staff mould be contacted regarding changes R2 might experience. been admitted to the hospital encerns, shortness of breath th had continued to decline of illness. F-A stated the scribed Azithromycin (antibiotic) y issues but the facility had not medication as ordered.		-Golden LivingCenter Slayton's poliprocedure for contacting families at physician with changes in condition cares. -On-call physician lists have been obtained by collaborating with clinic manager. -Licensed staff is educated on utiliz on-call physician services. -On admission of residents, it is polattempt to identify reactions to medications listed as allergies. -Licensed nurses will be educated system to ensure proper assessments residents -Random bi-monthly audits will be obtained and brought to QAPI. Education and immediate intervent took place at the time of the medicaterror. The medication error was reported DNS by Resident #2's family members.	ind or ing licy to on a ent of ion ation	
	prescribed Azithro respiratory infection stated that after the pharmacy to be notified facility stated an allergy for R2. Informed the physical respiratory in the physical respiratory infection of the physical respiratory in t	(DON) confirmed R2 had been mycin to treat an upper on (URI) [2/17/16]. The DON e prescription had been sent to e filled, the pharmacy had ff the medication was listed as The DON stated the staff had ician who had responded to the indicating the medication was		It is the policy of Golden LivingCent Slayton to administer medications it imely manner. If medication is deepossibly not obtainable within a time manner, the resident's physician winotified during clinic hours and the physician will be notifed after hours to obtain compliance.	n a emed ely II be on-call	

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F 309	still to be administer allergy symptoms. started on oxygen of saturation level me [diagnosis: upper rowas no further door record related to the 2/19/16, when the lassessment of R2 physician the follow thick yellow sputurn little or no air flow, addition, the fax indexing congested cough a 87% on room air." oxygen saturation in oxygen. In addition had not been admit in response, R2's padmitted directly to transport. During in DON stated F-A hamorning of 2/19/16 about R2's condition family was first mad received the physician. The DON stated getting the medicat with the pharmacy. When interviewed ophysician recalled to 2/16/16 or 2/17/16 Azithromycin for R2 physician confirmer with administering monitor for any allestated he'd heard in stated he'd heard in	ared, and for staff to monitor for The DON stated R2 was on 2/17/16, due to her oxygen asuring 70% on room air espiratory infection]. There umentation in the medical e use of the Azithromycin until DON conducted a physical and subsequently faxed to the ving: R2 had "a hoarse voice, in and very diminished, with middle lung lobes." In dicated R2 had a "tight and oxygen saturation measure The fax indicated R2's in mproved to 90-91% when on the fax identified the antibiotic instered as ordered 2/17/16. Only sician ordered that R2 be the hospital via ambulance atterview with the DON, the dobeen at the facility on the and had expressed concerning. The DON verified that R2's de aware that R2 had not can ordered antibiotic at that ted, "the ball was dropped" on tion for R2 and being persistent	F3	09	Random bimonthly audits of new or will be completed and the DNS or designee will review. Continued education will be provided as needed. Resident #32 pain has been reassed to prevent further occurance. Licer staff will be educated on pain contribution proper pain medication administrated followup for effectiveness. Random bimonthly audits of pain medication administration will be obtained. Rabimonthly audits for change of contribution will be obtained. Audits will be brought to QAPI.	ed. essed nsed ol and ion and n n	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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	PROVIDER OR SUPPLIER	_AYTON		STREET ADDRESS, CITY, STATE, ZIP CO 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		, , , , , , , , , , , , , , , , , , , ,
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F 309	stated after F-A had staff had contacted been assessed with sputum, and diminited The physician furth having prescribed to as an outpatient, an acquire and adminited attributed to Rifive days to treat her five days to treat her The following program R2's medical recommend noted results and stethoscope and noted feeling ill. Fax send daughter to be notifacility." On 2/13/16 at 5:29 nurse tor report [R2] not transferring we	een started. The physician d contacted him, the facility I him to inform him R2 had h hoarseness, thick yellow shed to no air flow mid lobes. For stated the rationale for the antibiotic was to treat R2 and the facility's failure to ester the prescribed antibiotics 2 requiring hospitalization for the respiratory symptoms.	F 3	09		
	cough. The docum "Residents condition has been more diff more edema to fee sounds diminished left. Frequent cough."	nented note included, on has changed this week. She icult to transfer and has had of and more cough Lung in right and sounds noted in h noted. Call placed to Dr. nospital and order received for				

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F 309	for Prednisone 60 r today and tomorrow Monday" An undated note do the progress notes returned from seeir were for Azithromyomg daily x 4 days. pharmacy). They residnet had an alle check with Doctor. stating start & moniagain faxed to (nan Thursday morning see what was happ I sent it last night, w fax it again, with the out on that evening cart to be put in MA record) once the mE-kit (emergency ma supply of this med 250 mg in stock." On 2/17/16 at 5:37 C-Pap per self throsaturation @ (at) 4:air). Applied PRN o L. (liters) Neb (nebu Oxygen increased this time 98% with 4:00 2/17/16, at 4:03	4 hours prn (as needed) and mg (milligrams) po (orally) wand to check with Dr on occumented on the back side of included, "On 2/16, residenting Drat clinic. New orders bein 500 mg first dose then 250 Order was sent to (name of eturned the order stating ergy to this medicine & double Resent to Dr& returned itro for reaction. This was me of pharmacy). On (name of pharmacy) calls to be promise that it would be sent run. Order was left on med are (medication administration edicine arrived. The EDU medication kit) was checked for d, & had only had one pill of a.m., "Resident removed ughout night. Oxygen 30 a.m. was 70% RA (room axygen via nasal cannula @ 4 dizer) treatment completed.	F3	09				
	allergy. (Name of p							

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F 309	11:39 a.m. included to visit today, has of medications. Disconstarted r/t allergy of daughter discovered intolerance not a treatment of this am (morning) a 2/18/16. Pt has all cough, very dm (dimid lobe down not clear. Resident sat oxygen. Resident from the sat drops to 87-88 dyspnea and denied Appears ill looking. Dr with above informatified." On 2/19/16, at 11:5 daughter about fax sounds, low grade oxygen on. Discussioned by the same preumonia downled to see wants to just see horesident can be semind. Call placed to fallergy. On 2/19/16, at 2:2 "1330 (1:30 p.m.) Not admit to hospital in agreement- Fax ambulance. Ambulet resident transfer	age 37 i.e." A subsequent notation at d, "resident's family member in concerns regarding resident overed antibiotic had not been oncern. Upon visiting with ed allergy to erithromycin is an ue allergy. Zithromycin started and prednisone started on noarse voice, congested tight minished) lung sounds from real air flow heard. Upper lobes is 90-91% with 2 liters of requently removes oxygen and is shortness of breath (sob). Temp 99.9 Fax sent to information and daughter is a doctor, discussed lung temp and resident not leaving sed she is not sob (short of a Daughter asked if she may iscussed it is possible but a doctor to determine this. She ow it goes for now. Discussed en at clinic if she changes her of (pharmacy name) to inform the notes included, MD returned faxed with orders in the notes included, sent to transfer per lance notifiedDaughter here ared at 1400 (2 p.m.)"	F 309				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245386	B. WING		····	03/	10/2016
	PROVIDER OR SUPPLIER	_AYTON		295	REET ADDRESS, CITY, STATE, ZIP CODE 7 REDWOOD AVENUE SOUTH AYTON, MN 56172	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	the message from allergy to Azithromy physician related to During review of R2 verified LPN-A had 2/16/16 to inform the allergy. However, the clinic after hours without there was no re 2/17/16 at approximate documented in the she'd sent the fax to physicians did not I concerns when it we further clarified she the fax to an on-cal	N)-A stated she had received the pharmacy regarding R2's yoin and had sent a fax to the of the concern about the allergy. 2's medical record it was sent a fax to the clinic on the physician of the resident's the fax had been sent to the hile the clinic was not open, response to the fax until mately 4:00 p.m. as progress notes. LPN-A stated to the clinic versus an on-call thad been her experience," like to deal with patient ras not their patient." LPN-A thad not considered sending II physician. LPN-A stated she sician would probably not get	F 3	09			
	pharmacy consulta have contacted the different medication pharmacy would not physician. The pha facility could have calternative medicat physician send the he wanted to go ah and the pharmacy prescription. When interviewed of DON and the administrative medicates and the pharmacy prescription.	on 3/8/16, at 1:47 p.m. the nt stated the facility should physician to identify whether a n would be appropriate as the ot typically contact the rmacy consultant stated the questioned the use of an ion and should have had the pharmacy an order to indicate lead and use the Azithromycin, would have filled the					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED				
		245386	B. WING _		03	/10/2016
	PROVIDER OR SUPPLIER	LAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	When interviewed stated LPN-B had in 2/19/16 while she was received the medic prescribed by the prescribed the medic the hospitalization prevented. When interviewed LPN-B stated she has about the Azithrom morning [2/13/16] and an allergy but a state of the physician to informaler to the prescribe pharmacy declined the physician. The clinical the fax was sent, the antibiotic to treat R staff finally received that the Azithromyomedication was still additional two days declining respirator antibiotic had been lt was observed on moved her head ar to be in pain. When	on 3/10/16, at 9:00 a.m. F-A informed F-A on the morning of was visiting R2, that R2 had not reation (Azithromycin) as physician. F-A stated if she at the concern to the DON's not sure it would have been reiterated that if R2 had reation as ordered, she (F-A) felt could potentially had been on 3/10/16, at 12:35 p.m. recalled having asked F-A ycin allergy for R2 on Saturday and F-A identified there was an intolerance instead. To promptly contact R2's him of the identified allergy ped Azithromycin. When the late of ill the prescription without proval, in lieu of contacting the retaff sent a fax to the resident's fic was closed for the day when the late of the	F 3(09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245386	B. WING _		03	/10/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	scheduled pain me which helped with a current pain level." R32's quarterly Mir assessment dated cognition, extensive transfer, walk in rounit, dressing, and assessment furthe frequent pain and medication regime. R32's care plan da potential for pain and diagnosis (dx) of great (abnormally excess cervicalgia (neck perior migraines, hochrof (R) arm/shoulder/mand pain below bilatincluded pain asseneeded), and to me pain/discomfort. The signed physici included: Tramado times a day for pain migraines and acetaminophe pain rated 5-9 out of the signed pour signed acetaminophe pain rated 5-9 out of the signed with the signed physici included: Tramado times a day for pain migraines and acetaminophe pain rated 5-9 out of the signed pain rated 5-9 out of th	ated that she received a edication earlier that morning the pain. R32 then rated the 8" on a scale of 1-10. Inimum Data Set (MDS) 2/26/16, indicated intact e assistance with bed mobility, om/corridor, locomotion on personal hygiene. The r indicated R32 experienced was on a scheduled pain experienced was on a scheduled pain experienced pain, kyphosis sive rounding of the back), ain), history of (h/o) chronic complaints of (c/o) right experienced pain, h/o abdominal pain experienced pain and report signs of pain orders dated 2/22/16, pointer and report signs of pain orders dated 2/22/16, pointer and report signs of pain experienced pain rating 1-5 out of 10; n 650 mg every 6 hours prn for pain rating 1-5 out of 10.	F 30	,			
	included: "At press of pain in that right the old CVA (cereb may be related to t	gress note dated 2/22/16 ent, she still complains of a lot arm, which may be related to rovascular accident/stroke) or he arthritic changes that have ht shoulder and arm. At					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245386	B. WING _		03	/10/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		, 10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 309	and see how she do controlled at prese. On 3/09/16, at 2:19 wheelchair in her rust her listening to the at that time, R32 stand felt "out of place rating of "8" out of light to request to sassistant (NA)-B el later and R32 requipractical nurse (LP experiencing in her room to alert the number of the therapist here. On 3/9/16, at 2:30 (RN)-C entered R3 arm was hurting ar further explained the and the therapist here. RN-C asked R32 if come and assess. that LPN-B be sum about it; R32 then seed that LPN-B was in palways in pain but the go out. R32 was of the elbow; R32 exhand straighten here comforted the reside have LPN-B talk wirequest.	ntinue to keep an eye on this loes with it; indicates that it is nt." 9 p.m. R32 was seated in from with a tray table in front of television. When interviewed tated her right arm was hurting ce"; R32 expressed a pain 10. R32 then activated her call speak to the nurse. Nursing intered the room a short time ested to speak to licensed N)-B about the pain she was right arm; NA-B exited R32's	F 30				
	room and question the (R) arm pain. I	ed the resident pertaining to R32 stated her upper arm was e couldn't extend it out straight.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245386	B. WING _		03.	/10/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	(R) arm; the arm reshe was able to pastated this had only therapist had done place. LPN-B indithat problem in the therapy staff were LPN-B further indic qualified to attemp place. LPN-B offe (acetaminophen) to and reassured her would be notified. The prin (as needed room; without asset the pain scale 1-10 On 3/9/16, at 2:51 room with the prin administering the rasked LPN-B what receiving. LPN-B scale 10. LPN-B and exited the room	I how far she could stretch her emained bent at the elbow and artially extend the forearm. R32 by happened once prior and the something to put it back into cated being unaware R32 had past and explained that no longer in the building. Cated nursing staff was not to put her arm back into red R32 prn Tylenol of see whether it would help if the pain continued the doctor R32 was agreeable to trying the pain according to the pain according to the pain according to the pain and the stated the Tylenol was 650 mg. The resident if she could rate to of 1-10; R32 rated her pain and a stated they would try this first m. The assessment of pain a prior to the administration of the same according to the resident was stated they would try this first m. The assessment of pain a prior to the administration of the same according to the could rate according to the administration of the administration of the same according to the pain and the pain	F 30	9			
	administration recorreceived acetamin 3/9/16, at 2:46 p.m eMAR did not indiciple. Review of t at 2:46 p.m. indical acetaminophen 65	ord (eMAR) indicated R32 ophen (Tylenol) 650 mg on the was ineffective; the eate a pain rating at the time the progress notes dated 3/9/16					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED					
		245386	B. WING			03/	10/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - SL	AYTON		2957	EET ADDRESS, CITY, STATE, ZIP CODE ' REDWOOD AVENUE SOUTH YTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	3/9/16, at 15:31 (3:3 administration was notes did not includ pain, the resident's of administration non-pharmacologic the stated ineffective. Further review of the indicated R32's schit times a day did not 4:00 p.m. dose. The scheduled Tramado of 9 out of 10 at the When interviewed director of nursing (administration/chardirectly linked from progress notes and of the resident's pain she would expect cof the resident's pain she was experienci stating, "No, because further stated havin when in the dining restaff, the nurse administration at the elbow and the numb. R32 indicate about her (R) arm to administered the screen and the state of the resident's pain the state of the continue as yesterday, statin at the elbow and the numb. R32 indicate about her (R) arm to administered the screen and the state of the state	he progress note dated 31 p.m.) indicated the prn ineffective. The progress e a site/description of R32's rating of the pain at the time or any follow-up or all interventions attempted with eness of the prn. e eMAR dated 3/9/16, eduled Tramadol 50 mg three include a pain rating for the e pain rating for the e pain rating for the 8:00 p.m. of dose indicated a pain rating time of administration. on 3/9/16, at 6:30 p.m. the DON) confirmed that ting of prn medication is the eMAR to the electronic should include a 1-10 rating n. The DON further stated harting to include the location n. 8 a.m. R32 was observed When questioned whether ng any pain. R32 denied se I had a pain pill." R32 g pain in her (R) arm earlier oom and when reported to ninistered a pain pill. R32 d to have the same problem g her (R) arm wouldn't release at her (R) hand and fingers felt ed that no nurse had inquired	F3	09			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/	10/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - SL	AYTON		295	EET ADDRESS, CITY, STATE, ZIP CODE 7 REDWOOD AVENUE SOUTH AYTON, MN 56172	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	R32 was given sche 8:00 a.m. with a pa of administration. When interviewed of confirmed giving R3 Tramadol, and furth c/o back and (R) arthat time. RN-B stated that time. RN-B stated that time always reported so scheduled Tramadol 10. RN-B stated that 9 last night were not RN-B stated R32 at use between scheduled pain administering printer document a chart in only rated the pain scheduled pain meconfirmed she wou progress note r/t paredication. When interviewed of LPN-B confirmed she pain to her knowledge with confirmed the pain to her knowledge with could recall the resipast. LPN-B again pain should have be	ge 44 eduled Tramadol 50 mg at in rating of 8 out of 10 at time on 3/10/16, at 11:58 a.m. RN-B 32 the scheduled 8:00 a.m. her confirmed the resident had m pain rated 8 out of 10 at ated the resident usually me pain when given the of but usually rated 4-5 out of e rating of 8 this morning and of typical (higher) for R32. Iso had prn Tylenol available to luled doses of Tramadol for RN-B stated when nedications, she would note related to the pain, but when administering the dication (Tramadol). RN-B Id not necessarily document a atin for the scheduled on 3/10/16, at 12:10 p.m. he had not documented a atin for the scheduled on 3/10/16, at 12:10 p.m. he had not documented a fining to R32's (R) arm pain on have done so. LPN-B further R32 described in the (R) arm as unusual as no other staff ident c/o this sort of pain in the confirmed R32's c/o (R) arm een documented even though ated the information during	F3	509				
	When interviewed on DON confirmed she	on 3/10/16, at 1:20 p.m. the e would expect prn ude a progress note						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				IPLE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		245386	B. WING _		03/10/2016	
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 309	the medication was assessment/locatio	nurse indicating the reason	F 30	09		
F 312 SS=D	2/10/15, under GUI pain and evaluating management interversal management scale self-report or object cognitively impaired assessment and interversal medication. Evaluation are corded in a concicare. Nursing staff pain evaluation and available." Under Mincluded: "Docume care and treatment pain levels and interversal management in the and non-pharmacol will be reflected on notes." 483.25(a)(3) ADL CODEPENDENT RES A resident who is undaily living receives maintain good nutril and oral hygiene. This REQUIREMENT by: Based on observations.	entions using a pain based on patient/resident tive assessment for the d. Documenting pain terventions prior to giving ation activities should be se manner per the plan of should utilize the electronic nursing note link when it is MONITORING/COMPLIANCE entation and observation of reflects ongoing monitoring of rventions (pharmacological logical). The documentation the eMAR and progress	F 31	R312 Golden LivingCenter Slayton's standa	4/15/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245386	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AYTON	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	living (ADLs). Findings include: On 3/7/16, at 11:11 R1 was observed ir fingernails with darl underneath the fing On 3/09/16, at 4:16 in bed while in his r long, jagged fingern present under the r fingernails were long facility had a class a where they soak the also file/trim and puasked whether staff in between and he whether he would a fingernails, R 1 respectively for Mentalso identified that lassistance with per dated 3/1/16, identified with interventions in care". Review of R1's eTA administration recoincluded: "clean, tr	a.m., and 3/8/16, at 2:09 p.m. his room with long, jagged to brown debris noted ternails on both hands. p.m. R1 was observed lying toom and continued to have hails with brown residue hails. R1 confirmed his g and soiled and stated the approximately once a week enails to clean them and will at polish on the nails. When froffer to clean his fingernails responded, "no." When asked allow staff to clean and trim his bonded affirmatively. The data set (MDS) (2/26/16, included a Brief I Status (BIMS) assessment ting intact cognition. The MDS R1 required extensive sonal hygiene. The care plan fied an alteration in self care including: "assist with nail and file finger and toe nails every month. [sic] in the	F 312	to provide necessary services to m grooming and personal hygeine. Resident #1 nail care was provided time of finding. All diabetic nail care will be completed assigned on the eTAR by licensed CNA staff will be educated on the aclean and file diabetic resident nail well as general nail care on all resine Nail audits will be comleted random brought to QAPI.	d at the eted as staff. ability to s as dents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING		03/	/10/2016	
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		JLD BE	(X5) COMPLETION DATE	
F 314 SS=G	nursing assistant (N responsible for trim diabetic. NA-A con cleaning R1's nails cooperative with as When interviewed director of nursing (responsible for resilicensed nurses we R1's nails. The DC be cleaning R1's nails as necessary. fingernails with survilong and soiled. DC expected R1's nails staff per the eTAR (month) and would hand file R1's nails at 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facil does not develop pindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores. This REQUIREMENT by: Based on observations.	on 3/10/16, at 10:50 a.m. NA)-A stated the nurses were ming R1's nails as he is firmed the NA's assist with in between and that R1 was sistance with ADL's. On 3/10/16, at 1:30 p.m. the DON) confirmed NA's were dent nail care and that the re responsible for trimming N verified the NA's should still alls and also could file R1's DON observed R1's veyor and confirmed they were DN stated she would have to be trimmed by nursing (trim on 15th and 30th of each have expected NA's to clean as needed per the plan of care. ENT/SVCS TO RESSURE SORES Orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that a lble; and a resident having eives necessary treatment and the healing, prevent infection and	F 3		en	4/15/16	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/	10/2016	
_	PROVIDER OR SUPPLIER I LIVINGCENTER - SI	AYTON		295	REET ADDRESS, CITY, STATE, ZIP CODE 57 REDWOOD AVENUE SOUTH AYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 314	care and services to development and/oulcers for 2 of 4 resonances who were identified development and hulcers. The failure is progression of the interventions could harm for R43 and Findings include: R43 was admitted listed on his active depression, anxiety falls and heart failurindicated the family services 2/15/16 reliver cirrhosis. During interview wire on 3/7/16 at 10:39 Stage III pressure to loss. Subcutaneous tendon or muscle is present but does not loss) which had dewhile R43 was a result of the interview for M14, indicating intaction identified R43 required mobility and dressing transfers and did not identified R43 with incontinence and a services in the interview of M14 incontinence and a services in the incontinence in	o reduce the risk of or deterioration of pressure sidents (R43, R5) reviewed at risk for pressure ulcer ad facility acquired pressure to assess and monitor the wounds to ensure appropriate be implemented, resulted in	F 3		reviewed and weekly wound audits been updated. Residents identified risk for the development for pressulcers or current ulcers has the porto be affected. Nursing staff will be educated to procares and services identified in the plan that promote healing of pressulcers. Licensed staff have been educated to documetation of woun weekly with recommended intervers and cares. Random bimonthly audits will be conducted until July 1st on residentified pressure ulcers to ensure and services offered promotes care healing of said ulcer, identify care printerventions, and documentation of wound care and changes. Audits will be presented at QAPI for reivew.	d as at ure tential rovide e care ure ntions ats with e cares es and plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING		03	/10/2016	
	PROVIDER OR SUPPLIER	LAYTON		STREET ADDRESS, CITY, STATE, ZIP COD 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 314	record identified th -12/31/15 Reside Small (1 centimete coccyx; foam dress time. Will continue -12/31/15, at 1:51 p bowel & bladder. H routinely. Has no s coccyx has red are absorbent, atraums polyurethane foam measures. No rest unable to move pe with all ADL's (active do anything per se -1/1/16, at 2:23 p.n. (nursing assistants open areas noted of have broken open, dressing applied, s keep off area wher tomorrow as today -1/4/16, at 1:28 p.n refusing to get out be repositioned fre breakdown and pn -1/5/16 Fax receive tegaderm to open a -1/11/16, at 2:49 p.	cumented in R43's medical e following: Int has redness on buttocks. In (cm) x 1.5 cm) opening on sing in place. Superficial at this to monitor. In the second is incontinent of let is checked and changed cheduled treatments but the anoted, Mepilix (an eatic dressing made from applied for preventive raints used as resident is reself. Needs extensive assist wities of daily living) - unable to lef at this time. In called to room by NAs and the started as blisters that the tegaderm foam adhesive the taff will reposition resident to a in bed. Will fax doctor is a holiday. In visited with resident about of bed frequently and need to quently to prevent further eumonia.	F3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245386	B. WING			03 /	10/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - SL	_AYTON		29	REET ADDRESS, CITY, STATE, ZIP CODE 57 REDWOOD AVENUE SOUTH .AYTON, MN 56172		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314	repositioning, dress meals, -1/14/16, at 10:30 a	extensive assist with sing, grooming, set up & eating a.m. has history of a pressure along below during prior facility	F3	14			
	admission, that has include an air overl pressure relieving of check and change and cleanliness, so	s healed. Current interventions ay mattress on his bed, a cushion on his geri-chair, a program for optimal dryness heduled turning/repositioning and use of air filled pressure					
	members with care pain issues. Tegade staff changes that of	o.m. Requires assist of 2 staff and with repositioning due to erm in place to coccyx and q day. Requires total assist the cares. Is repositioned q 2 ure area.					
	ADLs. Difficult to di Incontinent of bowe	o.m. Total dependence with all ress related to shoulder. el and bladder. Area on coccyx guineous drainage. Buttocks					
	therapy, occupation x/week for strength excoriated and tend	Receives PT/OT/ST (physical nal therapy, speech therapy) 5 sening. Coccyx area is very der, Carona (non-stick gel Will continue to monitor.					
	resident having bre area. Informed fax Propass (a protein repositioning/offloa	spoke with family regarding eakdown to sacral and coccyx has been sent to request supplement) and ding every 1 hour. Has low air ed and air boots to feet.					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245386	B. WING	 	03	/10/2016		
	PROVIDER OR SUPPLIER	AYTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 314	Receives supplemedenied pain today. The 3/9/16 care placoncern with poten integrity related to a communication def dribbling/incontiner cirrhosis of the liver appetite/intakes, his breakdown, history with a stage I coccy interventions included on bed, (2) pressure geri-chair, (3) Braddecub (decubitus usencourage food & be up & as active a report signs of skin pericare after incorrassessment weekly (assessment of the tissue to prolonged altered skin site per (12) Turn/reposition and (13) Weekly described onto his left is have a 4 x 4 foam of sacral area, and two above the sacral area area stated they were not of the wounds as the R43 onto his side with the sacral area area area.	ents bid (twice daily). Pt has an for R43 identified: skin tial for alteration in skin weakness, cognitive icit, urinary ice, bowel incontinence, r, edema, anemia, decreased story moisture associated skin of pressure ulcers, admitted yx decubitus. Care Plan led: (1.) Air overlay mattress re relieving cushion in en scale quarterly, (4) Daily lcer) monitoring, (5) fluid intakes, (6) Encourage to s possible, (7) Monitor and breakdown, (8) Provide stinent episodes, (9) Skin y, (10) Tissue tolerance testing tolerance of the resident's pressure), (11) Treatment to r M.D. (medical doctor) order, a and/or off-load every hour,	F 31	4				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245386	B. WING			03/	10/2016	
	PROVIDER OR SUPPLIER	AYTON		295	REET ADDRESS, CITY, STATE, ZIP CODE 7 REDWOOD AVENUE SOUTH AYTON, MN 56172	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION) T			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 314	repositioned hourly NA-B also stated a to feed R43 lunch shis recliner prior to R43 was noted to heel protectors on. R43's current physitreatments that inclaived 1. Calcium alginate following wound cleas Allevyn and tegade 2. Foam dressing to resident is scratchina. Bilateral air filled all times, except for 4. Turn/reposition at During observation 11:59 a.m. registers practical nurse (LPI R43 was noted to hover his coccyx regabove the foam dresting dressing was noted also noted to have (Partial thickness loshallow open ulcer without slough. May open/ruptured bliste PU of golf ball size his lower sacrum at pressure above the each wound with widressings to the work without slough to the work of the work of the sach wound with widressings to the work of the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach wound with widressings to the work of the sach work of the sach wound with widressings to the work of the sach work o	due to his declining condition. hospice aide usually came in to they would get R43 up into lunch. During this observation, lave an air bed and bilateral cian orders identified uded: with silver wound dressing canser then cover with rm every 5 days and PRN; or area on right hip where larg, change as needed; pressure relieving boots on at robathing; and/or off-load every one hour. of wound cares on 3/9/16, at led nurse (RN)-A and licensed li		:14				
		the following pressure ulcers:						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING _	·····	03	/10/2016
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP CO 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	(1) Stage I PU; -14 day assessmer Stage I PU; -30 day assessmer Stage I PU; -30 day assessmer Stage I PU; -Significant change identified (1) Stage The weekly skin as record were income did not correlate with wound evaluation The following was reassessments:. (1.) 1/14/16- identified (1.) 1/21/16- identified (2.) 1/21/16- identified (3.) 1/28/16 - identified (4.) 2/4/16- identified (5.) 1/28/16 - identified (6.) 1/28/16 - identified (7.) 1/28/16 - identified (8.) 1/28/16 - identified (9.) 1/28/16 - identified (1.) 1/28/16 -	ment dated 1/2/16, identified at dated 1/9/16, identified (1) at dated 1/23/16, identified (1) assessment dated 2/25/16, III PU. sessments documented in the olete and/or inaccurate as they that he MDS assessments and on flowsheet documentation. Noted on the weekly skin ited coccyx- no description of ited open areas on coccyx but oteristics. Ited skin intact; (wound unstageable and Stage I) and a large open area on en areas on bilateral buttocks; ace. Tracking, "Wound Evaluation of 1/28/16, identified R43 with an x 5 cm unstageable is coccyx and another Wound e same date 1/28/16, a second Stage I PU, x 1.5 cm on his left buttocks. pancy between the wound ets documentation and the otes. The documentation and the skin. A 3rd PU located on identified on 3/9/16, which	F 3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
	245386	B. WING			03/	10/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - S			STREET ADDRESS, CITY, STATE, ZII 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
evaluated on 1/28 wound was not rewhen it had increased cm Stage II open purely when interviewed director of nursing unaware that R43 she realized there assessing pressure of some of the lice. When interviewed facility nurse consumed assess pressumeded more training on 3/9/16, at 4:10 and verified during observed a PU on crease, approximal sized open area or blister looking area wound. On 3/10/16, at 6:58 and stated she wood or 3/3/16, but remet LPN-B identified R a larger sacral wound above the sacral a observed during drong 3/10/16, at 8:33 on 3/10/16, at	d identified on R43's sacrum /16, measured 1 cm x 1.5 cm evaluated again until 3/4/16, sed in size to a 2.3 cm x 2.1 pressure ulcer. on 9/9/16, at 1:00 p.m. the (DON) stated she was had 3 PU's. The DON stated was some inconsistency in e ulcers due to lack of training nsed staff. on 3/9/16, at 3:20 p.m. the ultant verified there were ense staff's ability to measure ure ulcers and stated staff	F3	814				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245386	B. WING _		03	/10/2016	
	PROVIDER OR SUPPLIER	AYTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	dressing. On 3/10/16, at 9:18 wounds and identifi #1-coccyx wound ir cm x 1.8 cm.; #2-s x 2 cm.; #3-addition periphery of the large 0.8 cm x 0.6 cm.; at the larger sacral words are larger sacral words are larger sacral words and documentation. Throughout review noted there was incompleted to his long of reporting or ongoulcers even when Frelated to his long of reporting or ongoulcers even when Frelated to his long of development. The reducer for the development or detulcers. R43 had degreater pressure ulfacility and continued deterioration and but the wound on R43 1/28/16, as a 1 cm evaluated again unprogressed to a 2.3 ulcer. There was expelled to the facility monitor the progressure ulcers as the fourth pressure	a.m. the DON measured R43 ed the following 4 open areas: a buttocks crease measured 2 acral wound measured 2.5 cm hal sacral wound on the ger sacral wound measured and #4 wound located above bund measured 1 cm x 1 cm. e was not aware of the supra sacral wounds. The bund had not been noted in found in the medical record. of R43's medical record it was consistent tracking, accuracy bing monitoring of pressure R43 was identified at high risk history of pressure ulcer medical record failed to wounds or show continuous R43's risk of further erioration of current pressure veloped four (4) stage II or cers since his admission to the ed to show risk for ongoing	F 3				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIF 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 314	hospital stay for reciside (fluid accumula diagnoses that incluid), osteoarthritis, mattack) and heart fachecks and insulin blood sugars were ranging from 57-54 adjustments made at the facility on 2/7 pelvic fractures and was subsequently has re-admitted to the facility on 2/18/11 assistance with bed During observations 1:54 p.m. it was not side with her head a pillow. During an observations 1:54 p.m. it was not side with her head a pillow. During an observativas noted that R5's scabbed area. At the noted the sore area December and explaying on her oxyge. During an observatical napplied treatment to wound was observed by 2 cm with a deptedges, gray wound redness surroundin observed to be a la reported was soft were recombered to some provided to the sore area of the sore recombered to be a la reported was soft were some provided to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to be a la reported was soft were side of the sore recombered to the sore recombered	current pleural effusion on right ation in the lung). R5 has other ation in the lung). R5 has other ade diabetes mellitus II (DM yocardial infarction (heart illure. R5 requires blood sugar based on a sliding scale. The usually high with some lows by with frequent insulin by the physician. R5 had a fall /16, sustained multiple left a left fracture to elbow and aspitalized until 2/11/16 when acility. The Minimum Data Set 6, R5 required extensive I mobility and transferring. Sof positioning on 3/8/16, at and right ear directly on the end on on 3/9/16, at 1:07 p.m. it is outer right ear had a bloody at time, R5 indicated she prior to admission in ained she received it from a tubing. Sition on 3/9/16, at 4:53 p.m. are (LPN)-B measured and the left buttock PU. The end to be 2.6 centimeters (cm) h of 0.3 millimeters, had rolled bed with a large area of g it. The heel ulcer was rege reddened area that LPN-B when pressure applied. LPN-B when pressure applied. LPN-B wheel wound and verified it	F 3				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
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F 314	sleeping in her rec no heel boot was e elevated on a pillow. Review of the Hea assessment dated open areas or press. Review of the nurs 1/22/16, identified blistered area on le measured 4 cm by had previously been otification was se When reviewing th R5's skin was iden redness until the 1 identified on the left progress notes. In note dated 1/26/16 on left side of butto and oozed serosar bloody drainage), but and cover a foam tegwound to be changeneeded. Review of the weed 2/23/16, indicated a foam tegwound to be changeneeded.	p.m. R5 was noted to be liner with the foot rest raised; wident nor were her feet w. Ith Status form: Skin 12/11/15, documented no sure ulcers. The progress notes dated R5 as having a dark reddened off side of buttocks which 2 cm, was tender to touch and in treated with barrier cream. A not to the physician on 1/22/16, we weekly skin assessments, tified as intact with no areas of 1/26/16, even though it was it buttock as noted in the nurse contrast, the nurse progress in indicated that a blistered area works appeared to have popped inguineous drainage (watery but no measurement taken. The line of the sacral grader on buttocks, not measured. On 2/5/16, R5's clinical visit to facility and graderm dressing to the sacral grader on buttocks currently skin assessment dated areas on buttocks currently	F 31	4		
	blistered area on lemeasured 4 cm by had previously been notification was se When reviewing th R5's skin was iden redness until the 1 identified on the left progress notes. In note dated 1/26/16 on left side of butto and oozed serosar bloody drainage), but Review of the weed 2/2/16, indicated a healing slowly but physician made a cordered a foam tegwound to be changeneeded. Review of the weed 2/23/16, indicated a covered with patch	eft side of buttocks which 2 cm, was tender to touch and an treated with barrier cream. A not to the physician on 1/22/16. The weekly skin assessments, tified as intact with no areas of /26/16, even though it was it buttock as noted in the nurse contrast, the nurse progress in indicated that a blistered area backs appeared to have popped inguineous drainage (watery but no measurement taken. Kly skin assessment dated in open area on buttocks, not measured. On 2/5/16, R5's clinical visit to facility and gaderm dressing to the sacral ged every 3 days and as				

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	DER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE, ZIP CO 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Revindicand also dark Revi 3/1/2 and furth in the Revi 3/3/2 acquibutto A fazulce blistorece revie ear viole ear vio	cated the dress had increased noted that wou center. R5 indicated R right ear (no mater reassessment erecord nor white work and right ear was sent to the ron coccyx, the eron back of leaved 3/4/16, to ew of the right eaves a Stage II, sh. iew of the week the word indicated on the right eaves a Stage II, sh. iew of the week the word indicated on the head indicated indicated on the head indica	e progress note for 2/27/16, ing was changed on coccyx in size and was odorous. It and had yellow edges with a icated it hurt more lately. Ally skin assessment dated in had an open areas coccyx easurements taken). No ents were available for review then requested from staff. And evaluation form dated eet indicated PU's were facility located on the left heel, left ar. Measurements were noted. The physician regarding the ereddened right ear and the eft heel. Physician orders were treat all 3 areas. Further ear wound evaluation noted the open, painful and tender to all skin assessment dated been area on buttocks only, not not of the ear and/or els. The Status form: Skin 2/11/16, (date of cated R5 had a pre-existing measured 1 cm by 2.4 cm and crape on back of left healed	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245386	B. WING		·····	03/ ⁻	10/2016
	PROVIDER OR SUPPLIER	LAYTON		29	TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH ILAYTON, MN 56172		
(X4) ID PREFIX TAG				X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	(MDS) assessmen R5 was at risk of d did not any when a anticipated MDS dowere no pressure us independent with sliving (ADLs). The 2/18/16, did not inculcers and required ADLs. The association (CAA) indicated redeveloping pressure for Mental Status (assessments indicated 12/11/15, incurred and after his region of the Tissue completed on 2/17 moderate risk for an oindication that reprior to and after his Review of the Tissue completed 12/16/1 normal after sitting review of the tissue indicated it was initial assessment never by staff. During review of the tissue indicated it was initial assessment never by staff.	ission Minimum Date Set t dated 12/18/15, indicated that eveloping pressure ulcers but dmitted. The discharge/return ated 2/7/16, indicated there ulcers and resident was upervision for activities of daily significant change MDS dated licate a presence of pressure d extensive assistance with ated Care Area Assessment sident was at risk for re ulcers. The Brief Interview BIMS) for all MDS ated R5 was cognitively intact. Ilen scale for predicting PU risk licated R5 was at risk for re sores. The Braden scale /16, indicated R5 was at leveloping PU and there was esident had an existing PU	F3	:14			

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		245386	B. WING			03/10/2016	
	PROVIDER OR SUPPLIER	AYTON		STREET ADDRESS, CITY, STATE 2957 REDWOOD AVENUE SC SLAYTON, MN 56172	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	nursing initials. The was not on the TAR in the nurses notes Review of the resid indicated there was skin integrity. The pincluded: (1) air ma relieving pad in whe pericare s/p dribblin scale quarterly, (4) and report signs of assessment weekly (8) treatment to alte On 2/28/16 the care intervention to turn/H (every 2 hours). O survey team entere revised to include in pressure wounds at M.D. order. When interviewed of director of nurses (I assessment of R5's documented. DON ordered ear treatment medication record in DON was unaware scabbing. She furth interventions put interventions put interventions put interventions schedule stallay her down and to	treatment for the right ear and no documentation noted that it was applied. ent's care plan initiated 1/1/16 a potential for alteration in lan and interventions ttress on bed and pressure elchair, (2) Assist with eg/incontinence, (3) Braden encourage fluids (5) monitor skin breakdown (6) skin (7) tissue tolerance testing, ered skin site per M.D. order. e plan was revised to add reposition and/or off-load q 2 on 3/8/16 (one day after d facility) the care plan was neterventions to culture and pressure ulcer care per encounty of the physician ent was not on the treatment for had not been initiated. The the ear was open with bloody er verified there were no oplace to relieve pressure	F3	314			

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	PROVIDER OR SUPPLIER	_AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	1 00	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 314	During an interview reported that she g before she fell [2/7/assisted with persowas sore; they told R5 stated, "They w that's all they did. Nore and tender. It that is why they lay During an interview verified the treatmet TAR as ordered by interventions noted worksheets. The identified wour follows: Left buttock measured blister ar 2/13/16-length 4 creddened blister ar 2/13/16-length 2.4, Undated wound eval cm, no depth, Sta 3/3/16-Wound eval 2.5 cm, no depth UHeel measurement 3/3/16-length 2 cm. Ear measurements 3/3/16-length 0.5 cm. Throughout review noted there was no of reporting nor one when R5 was ident development. The	ot the sore on her bottom long (16]. R5 stated that when staff anal care she informed them it her she had an open area. Ould put some cream on it and low its covered. It's still pretty hurts to sit on it too long so me down often". on 3/9/16, at 7:04 p.m. DON ent was not documented on the the physician nor were on the care plan and aid and ulcers were documented as a rements (identified 1/22/16): m, width 2 cm, no depth ea; width 1 cm; aluation week 1: 2.4 cm, width age I uation wk 2: length 2 cm, width instageable is (identified 2/23/16): m, width 2.5 cm.	F 31	4		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			E SURVEY MPLETED		
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-	PROVIDER OR SUPPLIER I LIVINGCENTER - SL	AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 314	the wounds nor or omonitoring to reduce development or detulcers. The Weekly Skin R directs skin alteration the figures provided and location. It furth flow was to be initiated to be notified and cwith new intervention pressure ulcer was. The wound on R5's on 1/26/16 as an open and not evaluated had progressed to a pressure ulcer. The harm related to the assess and monitor wounds. R5 remain further pressure ulcer. 483.60(b), (d), (e) ELABEL/STORE DR The facility must en a licensed pharmacof records of receip controlled drugs in accurate reconciliater records are in order controlled drugs is reconciled.	did it demonstrate continuous see R5's risk of further serioration of current pressure deview policy dated 5/1/15, con findings to be identified, used, describe type of alteration her directs a wound evaluation ated/updated, the MD/NP were are plans were to be updated ons. A policy related to requested and not submitted. If left coccyx was documented been blistered area 4 cm by 2 ed again until 3/3/16, when it a 2.5 cm x 2 cm open are was evidence R5 sustained facility's failure to accurately a the progression of identified and at risk for development of the left heel and right ear	F 43			4/15/16	

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F 431	professional princil appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and permit have access to the The facility must professional permanently affixe controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districtions.	nce with currently accepted ples, and include the sory and cautionary he expiration date when a State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to e keys. Trovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and a and other drugs subject to en the facility uses single unit ibution systems in which the ininimal and a missing dose can	F4	31			
	by: Based on observareview the facility for medications to ensure medications. This of the 38 residents Findings include: During the medicate p.m. licensed practobserved preparing scheduled to recei	NT is not met as evidenced ation, interview and document ailed to properly label and store sure safe administation of has the potential to affect any who reside in the facility. tion pass on 3/9/16, at 4:22 tical nurse B (LPN-B) was g medications for R2. R2 was we a Symbicort inhaler. The did not have a medication label			F431 R2 and R15 medications have beer reviewed for proper labeling. Pharr will complete cart audits of medicat labeling. Licensed staff have been educated labeling of OTC medication to ensu administration of medication. Random bimonthly audits will be completed until July 1st and brough QAPI.	nacy ion on re safe	

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		245386	B. WING _		03	/10/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - SL	AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	have a label on it be medication. During inspection of following medication Liquitears 1.4% eyed drops 3 bottles, Timand Lantaprost 0.00 addition, an open be drops was noted with bottle. The label on The medication was discontinued 2/8/16 Mucinex 600 mg with was evident and not buring interview with p.m. she verified the had a label on it. CLPN-B stated she of was stored in the cask now whether it was individual prescription. When interviewed director of nursing discontinued Oxyflothave had a label are discontinued. She should have the appresident's name. The policy PRODU PACKAGE TYPES medication orders of the policy products of the	etrieved a new inhaler that did efore administering the of the north/south cart the ns were found without labels: et drops 3 bottles, Systane eye holol eye drops 0.5% 1 bottle, 005% eye drops 1 bottle. In ottle of Oxyfloxin 0.3% eye the R15's name written on the the bottle said E-Kit 1/31/16. In ottle sordered 2/2/16 and S. A medication card of ith 9 pills remaining in the card of label was on the medication. In LPN B on 3/9/16, at 4:22 at R2's inhaler should have on 3/10/16, at 10:31 a.m. Itid not know why the Mucinex art and indicated she did not s a stock medication or an on for a resident.	F 43			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245386	B. WING		03/	/10/2016
	PROVIDER OR SUPPLIER	_AYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		JLD BE	(X5) COMPLETION DATE
F 431	appropriately and s have: 1. Any labeling regulation and profe 2. Expiration da or the manufacture is less	censed to residents are afely labeled. The label shall that is consistent with law, essional practice ates of a maximum of one year	F 4	131		

5386024

Printed: 03/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245386

B. WING

03/10/2016

NAME OF PROVIDER OR SUPPLIER

COLDEN LIVINGCENTER - SLAYTON

STREET ADDRESS, CITY, STATE, ZIP CODE

2957 REDWOOD AVENUE SOUTH

GOLDEN	· =: · : · · · · · · · · · · · · · · · ·	REDWOOD AVENUE SOUTH /TON, MN 56172				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR) OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	INITIAL COMMENTS	K 000				
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on March 10, 2016. At the time of this survey, Golden LivingCenter Slayton was found 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Golden LivingCenter Slayton was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected and is Type II(111) construction.					
	The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 38 at time of the survey.		į.			
	81					
	-2					
	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S		TITLE	(X6) DATE		

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

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.



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted March 25, 2016

Ms. Theresa Pridel, Administrator Golden Livingcenter - Slayton 2957 Redwood Avenue South Slayton, MN 56172

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5386026

Dear Ms. Pridel:

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

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the 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.

Golden LivingCenter - Slayton March 25, 2016 Page 2

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

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

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, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

(X6) DATE

PRINTED: 04/28/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00915 03/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH **GOLDEN LIVINGCENTER - SLAYTON** SLAYTON, MN 56172 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

Minnesota Department of Health

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

Electronically Signed 03/30/16

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AYTON 2957 RED	DRESS, CITY, S WOOD AVEN I, MN 56172	TATE, ZIP CODE IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department On March 7th, 8th, of this Department provider and the foliasued. Please indicate in your correction that you and identify the dat Minnesota Department be State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department or library status of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled "ID statute/rule out of column entitled" in statute/rule out of column entitled in statute/rule	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 9th and 10th, 2016, surveyors is staff, visited the above lowing correction orders are lour electronic plan of have reviewed these orders, when they will be completed. The ent of Health is documenting. Correction Orders using an umbers have been noted state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 7D8B11 If continuation sheet 2 of 69

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	ΔΥΙΩΝ	WOOD AVEI , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status		2 265			4/15/16
	A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:					
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision tresident from the n	o transfer or discharge the ursing home; or				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/10/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - SL	AVION		NUE SOUTH		
GOLDLI	TEIVINGOEITTEIT OF	SLAYTON	, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	E. expected an	d unexpected resident deaths.				
	This MN Requirement is not met as evidenced by:					
	facility failed to notification with timely manner for 1 for hospitalization with changes in her responded treatment. For R2, who experies and a congested tight physician notification prescribed antibiotic respiratory infection.	and document review, the fy the family and physician in a of 1 resident (R2) reviewed who experienced significant biratory condition requiring. This resulted in actual harm enced diminished lung sounds ght cough related to delayed on regarding failure to initiate a medication to treat an upper a, with subsequent transfer to for respiratory distress.		Corrected		
	Findings include:					
	telephone, R2's fan questioned about n significant change i health or status occoncern that R2 har prescribed by her p ago". F-A stated shomitted medication, when R2 required hrespiratory difficulties she had been contatreatment/medication felt this could have hospitalization for F primary family contawere aware she shomedical condition of F-A stated R2 had better the condition of F-A stated R2 had be significant to the condition of F-A stated R2 had be significant to the condition of F-A stated R2 had be significant to the condition of F-A stated R2 had be significant to the condition of F-A stated R2 had be significant to the condition of F-A stated R2 had be significant to the condition of t	on 3/7/16, at 2:35 p.m. via nily member (F)-A was otification by staff when a n the resident's physical curred. F-A stated she had a d not received a medication hysician," about two weeks e was not informed of the treatment until 3 days later rospitalization due to es. F-A further explained that if acted by the facility when the on had been prescribed, she potentially prevented R2. F-A stated she was the act for R2, and the facility staff bull be contacted regarding hanges R2 might experience. Deen admitted to the hospital acerns, shortness of breath				

Minnesota Department of Health

PRINTED: 04/28/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - SL	ΑΥΤΌΝ	WOOD AVE , MN 56172	NUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 265	Continued From page 4		2 265				
	since this episode of physician had preso for R2's respiratory administered the m	n had continued to decline of illness. F-A stated the cribed Azithromycin (antibiotic) issues but the facility had not edication as ordered.					
	director of nursing (prescribed Azithrom respiratory infection stated that after the the pharmacy to be	(DON) confirmed R2 had been hycin to treat an upper in (URI) [2/17/16]. The DON is prescription had been sent to if filled, the pharmacy had					
	an allergy for R2. T informed the physic pharmacy alert by it	the medication was listed as The DON stated the staff had cian who had responded to the ndicating the medication was					
	allergy symptoms. started on oxygen of saturation level mea	red, and for staff to monitor for The DON stated R2 was on 2/17/16, due to her oxygen asuring 70% on room air					
	was no further docurecord related to the 2/19/16, when the I	espiratory infection]. There umentation in the medical e use of the Azithromycin until DON conducted a physical					
	physician the follow thick yellow sputum	and subsequently faxed to the ring: R2 had "a hoarse voice, a and very diminished, with middle lung lobes." In					
	addition, the fax ind congested cough a 87% on room air."	licated R2 had a "tight nd oxygen saturation measure The fax indicated R2's					
	oxygen. In addition, had not been admir	mproved to 90-91% when on the fax identified the antibiotic distered as ordered 2/17/16.					
	admitted directly to transport. During in	the hospital via ambulance terview with the DON, the					
	morning of 2/19/16,	d been at the facility on the , and had expressed concern n. The DON verified that R2's					

Minnesota Department of Health

STATE FORM 6899 7D8B11 If continuation sheet 5 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	WOOD AVE	NUE SOUTH		
(X4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	I, MN 56172	PROVIDER'S PLAN OF CORRECT	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 265	Continued From pa	ge 5	2 265			
	received the physic time. The DON stat	de aware that R2 had not ian ordered antibiotic at that ed, "the ball was dropped" on ion for R2 and being persistent				
	physician recalled ti 2/16/16 or 2/17/16 a Azithromycin for R2 physician confirmed with administering t monitor for any alle stated he'd heard n when F-A contacted antibiotic had not be stated after F-A had staff had contacted been assessed with sputum, and diministrate The physician further having prescribed that an outpatient, an acquire and adminishad attributed to R2 five days to treat her	on 3/8/16, at 1:32 p.m. R2's the facility faxing him on either asking about administering the 2's respiratory symptoms. The 3 he'd ordered staff to proceed the medication and for staff to 1 rgy symptoms. The physician othing further until 2/19/16 thim to inform him the 1 the een started. The physician of contacted him, the facility him to inform him R2 had a hoarseness, thick yellow shed to no air flow mid lobes. For stated the rationale for the antibiotic was to treat R2 and the facility's failure to 1 ster the prescribed antibiotics of requiring hospitalization for the respiratory symptoms.				
	On 2/12/16 at 12:00 room and noted res wheeze heard. 2+ e Resident has freque when lying down. Repisodes with edem signs) obtained and stethoscope and no left lobes sounded on the signs of the signs of the sounded of the signs of the sounded of the signs of the sig					

Minnesota Department of Health

STATE FORM 6899 7D8B11 If continuation sheet 6 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00915	B. WING	·····	03/1	0/2016
	PROVIDER OR SUPPLIER	AYTON 2957 RED		STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	daughter to be notificated facility." On 2/13/16 at 5:29 nurse tor report [R2 not transferring welfamily had also reported family had been more difficated for the family of the progress of the progress notes returned from seein were for Azithromyomy daily x 4 days. They are sidnet had an allest check with Doctor. Stating start & monitagain faxed to (name Thursday morning (see what was happed I sent it last night, we fax it again, with the out on that evening cart to be put in Marecord) once the med E-kit (emergency medical faxed for the face of the face o	ge 6 fied when she comes in p.m., family approached this y was not waking up today and I. The note indicated the orted R2 had a frequent ented note included, n has changed this week. She cult to transfer and has had t and more cough Lung in right and sounds noted in n noted. Call placed to Dr. ospital and order received for 4 hours prn (as needed) and ng (milligrams) po (orally) v and to check with Dr on cumented on the back side of included, "On 2/16, resident ng Drat clinic. New orders bin 500 mg first dose then 250 Order was sent to (name of eturned the order stating ergy to this medicine & double Resent to Dr& returned tro for reaction. This was the of pharmacy). On (name of pharmacy) calls to ening with order. I stated that where upon she asked me to the promise that it would be sent run. Order was left on med usedication administration edicine arrived. The EDU the dication kit) was checked for did, & had only had one pill of	2 265			

6899

Minnesota Department of Health STATE FORM

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - SL	AYTON	WOOD AVEI , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	On 2/17/16 at 5:37 C-Pap per self thro saturation @ (at) 4: air). Applied PRN of L. (liters) Neb (nebut Oxygen increased in this time 98% with a constant Azithron allergy. (Name of post of p	a.m., "Resident removed ughout night. Oxygen 30 a.m. was 70% RA (room xygen via nasal cannula @ 4 lizer) treatment completed. to 96%. Oxygen saturation at 4 L oxygen." p.m. "Fax returned from mycin as ordered & monitor for	2 265			

Minnesota Department of Health

STATE FORM 6899 7D8B11 If continuation sheet 8 of 69

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	WOOD AVEI , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 8	2 265			
		en at clinic if she changes her o (pharmacy name) to inform				
	"1330 (1:30 p.m.) Note to admit to hospital in agreement- Fax ambulance. Ambul	4 p.m. the notes included, MD returned faxed with orders Daughternotified et (and) sent to transfer per lance notifiedDaughter here red at 1400 (2 p.m.)"				
	practical nurse (LP) the message from allergy to Azithromy	3/08/16, at 3:19 p.m. licensed N)-A stated she had received the pharmacy regarding R2's with and had sent a fax to the the concern about the allergy.				
	verified LPN-A had 2/16/16 to inform the allergy. However, the clinic after hours where the she'd and the she'd sent the fax to provider because it physicians did not be fax to an on-caller.	progress notes. LPN-A stated of the clinic versus an on-call had been her experience," like to deal with patient as not their patient." LPN-A had not considered sending I physician. LPN-A stated she sician would probably not get				
	pharmacy consulta have contacted the different medication pharmacy would no	on 3/8/16, at 1:47 p.m. the nt stated the facility should physician to identify whether a would be appropriate as the of typically contact the rmacy consultant stated the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	00915	B. WING		03/	10/2016
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOLDEN LIVINGCENTER - SL	ΔΥΤΩΝ	DWOOD AVEN N, MN 56172	UE SOUTH		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
alternative medication physician send the phe wanted to go ahe and the pharmacy was prescription. When interviewed on DON and the adminishave been a more tiantibiotic prescribed. When interviewed on stated LPN-B had in 2/19/16 while she was received the medical prescribed by the pheory. F-A) hadn't brought attention she was not taken care of. F-A received the medical the hospitalization of prevented. When interviewed on LPN-B stated she readout the Azithromy morning [2/13/16] and an allergy but are about the Azithromy morning [2/13/16] and an allergy but are sidentified the facility resident's physician physician assistant, A. An accident occurant required potentic states and the present occurant required potentic physician assistant,	uestioned the use of an on and should have had the charmacy an order to indicate ead and use the Azithromycin, would have filled the an 3/8/16, at 3:25 p.m. the histrator verified there should imely follow up regarding the by the physician. In 3/10/16, at 9:00 a.m. F-A afformed F-A on the morning of eas visiting R2, that R2 had not eation (Azithromycin) as anysician. F-A stated if she at the concern to the DON's ot sure it would have been enterated that if R2 had eation as ordered, she (F-A) felt would potentially had been enterated that if R2 on Saturday and F-A identified there was an intolerance instead. Notification of Change in eatus, revised 11/11/15, would consult with the purse practitioner or				

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-	NT OF DEFICIENCIES OF CORRECTION					
		00915	B. WING		03/1	10/2016
	PROVIDER OR SUPPLIER	AVTON 2957 REI		STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	status (i.e. deteriora psychosocial status conditions or clinica C. A need to alter traced to discontinue due to adverse connew form of treatme assessment approximmediate (defined no longer than 24 h D. A decision to trace. expected or une: The facility failed to physician to inform alert to the prescrib pharmacy declined the physician's appron-call physician, siphysician. The clinicate fax was sent, the antibiotic to treat Rastaff finally received that the Azithromyc medication was still additional two days declining respirator antibiotic had been SUGGESTED MET. The director of nursidirector could deve and procedure for rephysician related to for which treatment educate all nursing	ation in health, mental or in either life threatening al complications. The eatment significantly (i.e. a sean existing form of treatment sequences, or to commence a sent. Depending on nursing priate notification may be a in policy as soon as possible sours) to 48 hours. The promptly contact R2's him of the identified allergy and Azithromycin. When the to fill the prescription without roval, in lieu of contacting the taff sent a fax to the resident's cowas closed for the day when the efform R2's physician in should be administered, the land administered for an and R2 was hospitalized due to a systatus, URI, for which the originally ordered. THOD FOR CORRECTION: Sing (DON) and medical lop and implement a policy notification of family and a significant resident conditions is required. The DON could staff to the policy. The quality surance committee could do notice compliance.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - SL	AYTON	WOOD AVE , MN 56172	NUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 265	Continued From pa	ge 11	2 265				
	Twenty-One (21) days.						
2 555	5 MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development		2 555			4/15/16	
	must develop a con each resident withir completion of the con assessment as deficomprehensive plan by an interdisciplina attending physician responsibility for the appropriate staff in the resident's needs practicable, with the	lopment. A nursing home apprehensive plan of care for a seven days after the comprehensive resident and in part 4658.0400. The anof care must be developed ary team that includes the a registered nurse with a resident, and other disciplines as determined by a s, and, to the extent a participation of the resident, guardian or chosen					
	by: Based on observati review the facility fa	ons, interview and document liled to revise the plan of care (R5) who was reviewed for		Corrected			
	Findings include:						
	1:54 p.m. R5 was o	s of positioning on 3/8/16, at bserved lying on her right side sting on the bed pillow.					
	was observed to be both her feet resting	on on 3/9/16, at 7:12 p.m. R5 sleeping in her recliner with g on the foot rest; without heel at elevated on a pillow.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/	10/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RE	DDRESS, CITY, S DWOOD AVEN N, MN 56172	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 555	During a observation was observed R5's scabbed area. At the noted a sore on her on 12/11/15. R5 fur sore by laying on her Review of the week indicated R5 was incear (no measureme evaluation dated 3/measurements to be width with an intervial pillow. Review of the 2/23/16, R5 was ide to the right heel. Redated 3/3/16, identified to be 2.0 cm length intervention that incleft heel. Review of the resid 1/1/16 identified R5 alteration in skin intinterventions include and pressure relievely assist with pericare post]dribbling/inconquarterly, (4) encoreport signs of skin assessment weekly (8) treatment to alter No interventions that heel protector were During an interview director of nursing (had not been revise related to R5's pressure relate	on on 3/9/16, at 1:07 p.m. it is outer right ear had a bloody nat time, R5 indicated she right ear prior to admission ther revealed she obtained the er oxygen tubing. Sy skin review dated 3/1/16, lentified with a reddened right ents). Review of the wound 3/16, identified right ear see 0.5 cm length and 1.0 cm ention that included a neck e weekly skin review dated entified with a pressure ulcer eview of the wound evaluation fied the left heel measurement by 2.5 cm width with an eluded a heel protector to the ent's care plan initiated on eas having a potential for regrity. The plan and ed: (1) air mattress on bed ing pad in wheelchair, (2) s/p [status tinence, (3) Braden scale urage fluids (5) monitor and breakdown (6) skin (7) tissue tolerance testing ered skin site per M.D. order. at included a neck pillow or a				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	A. BUILDING:		
		00915	B. WING		03/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	ΔΥΙΩΝ	WOOD AVE , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	SUGGESTED MET The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon are providing care a of care.	ge 13 Protector to the left heel. THOD OF CORRECTION: Sing (DON) or designee could policies and procedures related to plan for each individual. The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan. R CORRECTION: Twenty-one	2 555			
2 565	Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident		2 565			4/15/16
	by: Based on observati review the facility fa for 2 of 4 residents identified at risk for and had facility acq	ent is not met as evidenced on, interview and document ailed to follow the plan of care (R2, R5) reviewed who were pressure ulcer development uired pressure ulcers and for 1) reviewed who required oming.		Corrected		
		on 12/28/15 with diagnoses care plan that included:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED	DRESS, CITY, S WOOD AVEI , MN 56172	STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	anemia, depression repeated falls and helected hospice ser stage liver cirrhosis. When interviewed oregistered nurse (Rhad a Stage III presegion which had doresident at the facility region which had doresident at the facility related to woommunication definited integrity related to woommunication included integrity and integrity integrity integrity. All the provided integrity in	an, anxiety, vertebral fractures, heart failure. On 2/15/16 family vices related to diagnosis end on 3/7/16, at 10:39 a.m. the N) case manager stated R43 source ulcer on the sacral eveloped while R43 was a ty. ed 3/9/16, identified: skin hial for alteration in skin veakness, cognitive ficit, urinary fice, bowel incontinence, fice, edema, anemia, decreased story moisture associated skin of pressure ulcers, and fige I coccyx decub. Find the care plan included: firess on bed-pressure geri-chair; finarterly; finitoring; file and sactive as possible; fort signs of skin breakdown; file after incontinent episodes; filtered skin site per M.D. order; and/or off-load every hour; tus update; on 3/9/16, at 10:38 a.m. NA)- B and NA-C entered	2 565			

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STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016
NAME OF PROVIDER OF	SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCE	NTER - SI	AYTON	WOOD AVEI , MN 56172	NUE SOUTH		
PREFIX (EACH	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 x 4 non-NA-B and under ead aware of they were while the wounds. I hourly wit aide usual would get noted to his protectors. During obtaining the state of the protectors over his cabove the The 4 x 4 dressing walso noted his coccyclic circumferial dime sizulcer. RN cleanser at R43's Mirridentified radmission (1) Stage I Pland and Stage I Pland available of the stage I Pland award stage I Pland award awar	over located stick dress. NA-C stack dressing the character usually properties and in the character was an analysis on. servation are gister on the character of the character	ed over his sacral area, and (2) ssings above the sacral area. ated R43 had open areas in gand stated they were not octeristics of the wounds as positioning R43 onto his side is providing treatment to the cated R43 was repositioned ining condition and a hospice in to feed R43 lunch so they not recliner prior to lunch. R43 in bed and bilateral heel of wound cares on 3/9/16, at eed nurse (RN)-A and licensed N)-B performed wound cares. In ave a large foam dressing gion and two 4 x 4 dressings essing on his sacrum region. It directly above the foam to have drainage. R43 was a quarter sized Stage II PU on the III PU of golf ball size round on his lower sacrum and the II pressure above the sacral sed each wound with wound plied dressings to the wounds. It as Set (MDS) assessments the following pressure ulcers: ment dated 1/2/16, identified (1) assessment dated 2/25/16, identified (1) assessment dated 2/25/16, identified (1) assessment dated 2/25/16, identified (1)	2 565			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - SLAYTON (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 16 The facility wound tracking, "Wound Evaluation Flowsheet", initiated 1/28/16, identified R43 with a 11.5 centimeter (cm) x 5 cm unstageable pressure area on his coccyx and another Wound evaluation dated the same date 1/28/16, identified R43 with a second Stage I PU, measuring 1.0 cm x 1.5 cm on his left buttocks.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
GOLDEN LIVINGCENTER - SLAYTON 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 16 The facility wound tracking, "Wound Evaluation Flowsheet", initiated 1/28/16, identified R43 with a 11.5 centimeter (cm) x 5 cm unstageable pressure area on his coccyx and another Wound evaluation dated the same date 1/28/16, identified R43 with a second Stage I PU, measuring 1.0 cm x 1.5 cm on his left buttocks.		
SLAYTON, MN 56172 (X4) ID PREFIX TAG COMPLETIVE NOTION TO THE APPROPRIATE DEFICIENCY) 2 565 Continued From page 16 The facility wound tracking, "Wound Evaluation Flowsheet", initiated 1/28/16, identified R43 with a 11.5 centimeter (cm) x 5 cm unstageable pressure area on his coccyx and another Wound evaluation dated the same date 1/28/16, identified R43 with a second Stage I PU, measuring 1.0 cm x 1.5 cm on his left buttocks.	NAME OF PROVIDER OR SUPPLIER	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 16 The facility wound tracking, "Wound Evaluation Flowsheet", initiated 1/28/16, identified R43 with a 11.5 centimeter (cm) x 5 cm unstageable pressure area on his coccyx and another Wound evaluation dated the same date 1/28/16, identified R43 with a second Stage I PU, measuring 1.0 cm x 1.5 cm on his left buttocks.	GOLDEN LIVINGCENTER - SL	
The facility wound tracking,"Wound Evaluation Flowsheet", initiated 1/28/16, identified R43 with a 11.5 centimeter (cm) x 5 cm unstageable pressure area on his coccyx and another Wound evaluation dated the same date 1/28/16, identified R43 with a second Stage I PU, measuring 1.0 cm x 1.5 cm on his left buttocks.	PREFIX (EACH DEFICIENCY	
There was no documented tracking of the wounds up to the date of these evaluations even when the progress notes identified R43 had other pressure ulcers prior to the ones indicated on the evaluation forms. The facility identified a 3rd PU located on R43's sacrum on 3/9/16, which measured 0.5 cm x 1.0 cm. Weekly skin assessments noted in the record were incomplete or inaccurate based on the evaluation of the whole medical record. The following skin assessment were identified in R43's medical record. 1. 1/14/16 weekly skin assessment just identified coccyx with no description of wounds. 2. 1/21/16 skin assessment identified open areas on coccyx but no details of characteristics. 3. 1/28/16 skin review identified a large open area on coccyx. Multiple open areas on bilateral buttocks. Dressings in place. During interview with the director of nursing (DON) on 3/9/16, at 1:00 p.m. the DNS stated she was unaware that R43 had 3 pressure ulcers. The DON stated she realized there was some inconsistency in assessing pressure ulcers due to lack of training of some of the licensed staff related to pressure ulcers. The DON verified there were not weekly skin assessments, daily	The facility wound to Flowsheet", initiated 11.5 centimeter (cm pressure area on his evaluation dated the identified R43 with a measuring 1.0 cm or there was no document wounds up to the day when the progress of pressure ulcers price evaluation forms. The facility identified sacrum on 3/9/16, where we incomplete or evaluation of the whollowing skin assess were incomplete or evaluation of the whollowing skin assess R43's medical reconstruction of the whollowing skin assess on coccyx with no descended at 1/21/16 skin assess on coccyx but no descended at 1/28/16 skin review on coccyx. Multiple buttocks. Dressings During interview with (DON) on 3/9/16, at she was unaware the The DON stated she inconsistency in assess lack of training of so related to pressure	

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING			
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	ΑΥΤΟΝ)WOOD AVEI I, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	nge 17	2 565			
		or monitoring and reporting down as directed by the care				
	consultant was inte were concerns abo	p.m. the facility nurse erviewed and verified there out license staff's ability to ss pressure ulcers and stated training.				
	was interviewed an dressing change sh on R43's buttocks, approximately quar open area on sacra	p.m. registered nurse (RN)-C d verified during morning ne observed a pressure ulcer in his buttocks crease, ter sized, a golf ball sized al region and a popped blister sized, on her supra sacral				
	(LPN)-B was interv with R43 either on a remembers R43 had identified R43 had larger sacral wound above the sacral ar	a.m. licensed practical nurse iewed and stated she worked 3/2/16 or 3/3/16, but ad 3 open areas. LPN-B a wound on his coccyx, a d, and 1 a smaller wound rea which would correlate with d during dressing change 1/16.				
	was interviewed an NA with R43 the pro	a.m. nursing assistant (NA)-F d stated she had worked as a evious week and R43 had a two additional dressings on foam dressing.				
	room and measure identified with the for Coccyx wound in b	B a.m. the DON entered R43's of R43 wounds. R43 was ollowing open areas. uttocks crease measured 2 cm ound measured 2.5 cm x 2 cm.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED	DRESS, CITY, S WOOD AVEN , MN 56172	STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Another sacral would larger sacral wound. The wound above to measured 1 cm x 1 not aware of the sulfing wounds. The periph been noted in any compared of the sulfing wounds. The periph been noted in any compared of the sulfing wounds. The periph been noted in any compared of the sulfing wounds. The periph been noted in any compared of the sulfingernails with dark underneath the fing on 3/09/16, at 4:16 in bed while in his relong, jagged fingern present under the note of the sulfingernails were long facility had a class a where they soak the also file/trim and pure asked whether staff in between and he whether he would a fingernails, R 1 responsible for the sulfingernails, R 1 responsible for trim diabetic. NA-A concleaning R1's nails	nd on the periphery of the I measured 0.8 cm x 0.6 cm. he larger sacral wound cm. The DNS stated she was pra sacral or peripheral sacral neral sacral wound had not	2 565			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - SL	AYTON	DWOOD AVEN N, MN 56172	IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 19	2 565			
	director of nursing (responsible for resilicensed nurses we R1's nails. The DC be cleaning R1's nails as necessary. fingernails with surviong and soiled. DC expected R1's nails staff per the eTAR (month) and would hand file R1's nails a R5 was admitted or hospital stay for reciside (fluid accumula diagnoses that includes	on 3/10/16, at 1:30 p.m. the (DON) confirmed NA's were dent nail care and that the re responsible for trimming on verified the NA's should stials and also could file R1's DON observed R1's yeyor and confirmed they were to be trimmed by nursing (trim on 15th and 30th of each nave expected NA's to clean as needed per the plan of care and 12/11/15, following a 9 day current pleural effusion on right ation in the lung). R5 has other ude diabetes mellitus II (DM yocardial infarction (heart tillure.	e 1.			
	was a potential for a plan and intervention on bed and pressur (2) Assist with perion (3) Braden scale quality (5) monitor and rep (6) skin assessment	atted on 1/1/16, indicated there alteration in skin integrity. The ons included: (1) air mattress re relieving pad in wheelchair, care s/p dribbling/incontinence parterly, (4) encourage fluids ort signs of skin breakdown at weekly (7) tissue tolerance int to altered skin site per M.D.	9,			
	licensed practical n applied treatment to ulcer. The ulcer wa centimeters (cm) b millimeters. The pre	tion on 3/9/16, at 4:53 p.m. urse (LPN)-B measured and the left buttock pressure s observed to be 2.6 by 2.0 cm with a depth of 0.3 essure ulcer was identified to and a gray wound bed with a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	10/2016
GOLDEN LIVINGCENTER - SLAVTON 2957 RED				STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	large area of rednessing an interview reported that she go before she fell [2/7/assisted with persowas sore; they told R5 stated, "They we that's all they did. No sore and tender. It is that is why they lay that is why they lay bocumentation reveassessments did not measurements to not part of the weekly sin the care plan. Doprogress notes date having a dark redder of buttocks which make the area was tended been treated with bodated 1/26/16, indicated a dressing identified the ulcer indicated a dressing identified the would dark center. R5 ind Review of the week indicated an open as slowly but not measurements. The measurements. The measurements in the care of the week indicated an open as slowly but not measurements. The measurements is the control of the week indicated an open as slowly but not measurements. The measurements. The measurements is the control of the week indicated an open as slowly but not measurements. The measurements.	ass surrounding it. 3/9/16, at 1:00 p.m. R5 but the sore on her bottom long 16]. R5 stated that when staff hal care she informed them it her she had an open area. build put some cream on it and low its covered. It's still pretty hurts to sit on it too long so me down often". Bealed the weekly skin but include wound honitor progress/decline as kin assessments as identified but				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
		00915	B. WING		03/	10/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RE	DDRESS, CITY, S DWOOD AVE N, MN 56172		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	assessment dated on buttocks only, no buttocks only, no assessments and a skin monitoring, this for R5's left buttock the wound had not indicate whether he since the weekly sk consistent monitoring wound, it was difficult the PU. When interviewed of director of nursing ulcer on the left but appropriately meas measurements so the assessed. SUGGESTED MET facility could review for following the core develop and provide following the care pursing documental impaired skin integrated by the compliance of the period of	taken). The weekly skin 3/8/16, indicated open areas	y y			
2 570	(21) days. MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			4/15/16

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	•	DDRESS, CITY.	STATE, ZIP CODE	1 00/1	0/2010
GOLDEN	N LIVINGCENTER - SI	2957 RE	DWOOD AVE	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	care must be review interdisciplinary teal physician, a register for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requirem by: Based on observative the facility for 1 of 4 residents pressure ulcers. Findings include: During observation 1:54 p.m. R5 was owith her right ear result was observed to be both her feet restin protector on nor feet was observed R5's scabbed area. At the noted a sore on he on 12/11/15. R5 fur sore by laying on his	i. A comprehensive plan of wed and revised by an am that includes the attending ared nurse with responsibility of other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal in representative at least in seven days of the revision of a resident assessment required subpart 3, item B. Lent is not met as evidenced alled to revise the plan of care (R5) who was reviewed for the setting on the bed pillow. In sof positioning on 3/8/16, at observed lying on her right side esting on the bed pillow. In on 3/9/16, at 7:12 p.m. R5 as sleeping in her recliner with gon the foot rest; without hee et elevated on a pillow. In on 3/9/16, at 1:07 p.m. it is outer right ear had a bloody that time, R5 indicated she ar right ear prior to admission of the revealed she obtained the		Corrected		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
	00915		B. WING		03/1	0/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - SL	AYTON		NUE SOUTH			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, MN 56172	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
2 570	Continued From pa	ge 23	2 570				
	ear (no measureme evaluation dated 3/measurements to be width with an intervibillow. Review of th 2/23/16, R5 was ide to the right heel. Redated 3/3/16, identition be 2.0 cm length intervention that incleft heel.	dentified with a reddened right ents). Review of the wound 3/16, identified right ear on 0.5 cm length and 1.0 cm ention that included a neck weekly skin review dated entified with a pressure ulcer eview of the wound evaluation fied the left heel measurement by 2.5 cm width with an eluded a heel protector to the					
	Review of the resident's care plan initiated on 1/1/16 identified R5 as having a potential for alteration in skin integrity. The plan and interventions included: (1) air mattress on bed and pressure relieving pad in wheelchair, (2) assist with pericare s/p [status post]dribbling/incontinence, (3) Braden scale quarterly, (4) encourage fluids (5) monitor and report signs of skin breakdown (6) skin assessment weekly (7) tissue tolerance testing (8) treatment to altered skin site per M.D. order. No interventions that included a neck pillow or a heel protector were in the plan of care						
	director of nursing of had not been revised related to R5's press and left heel; which right ear and heel publications SUGGESTED MET The director of nursidevelop and impler	on 3/09/2016, at 7:04 p.m. (DON) verified the care planed to include interventions sure ulcers to the right ear included a neck pillow to the protector to the left heel. THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures revisions. The DON or					
	designee, could pro	ovide training for all nursing timeliness of care plan					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - SI	ΔΥΤΩΝ	, MN 56172	NUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ige 24	2 570				
	revisions. The quality assessment and assurance committee could perform random audits to ensure compliance.						
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.052 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			4/15/16	
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.						
	by: Based on interview facility failed to provand services for 1 cwho had been hospactual harm for R2 lung sounds, thick congested cough reassessment, delayed physician, delayed treatment and subsfacility due to respin	and document review, the vide adequate nursing care of 1 resident (R2) reviewed bitalized. This resulted in who experienced diminished yellow sputum and a tight elated to delayed nursing ed notification of the family and administration of antibiotic sequent transfer to an inpatient ratory difficulties. In addition, consistently assess and		Corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - SL	ΔΥΤΩΝ	DWOOD AVEI N, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	document monitorir (R32) reviewed who Findings include: When interviewed of telephone, R2's fam questioned about not significant change is health or status occoncern that R2 has prescribed by her pago". F-A stated show itted medication, when R2 required horespiratory difficulties she had been contattreatment/medication felt this could have hospitalization for Forimary family contawere aware she show ith respiratory contand that R2's health since this episode of physician had presofor R2's respiratory administered the modified facility staff an allergy for R2. The staff an allergy for R2.	ng of pain for 1 of 3 residents				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	WOOD AVEI , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	pharmacy alert by is still to be administe allergy symptoms. started on oxygen of saturation level measuration level measuration level measuration level measuration level measuration level measuration for assessment of R2 aphysician the follow thick yellow sputum little or no air flow, raddition, the fax indicongested cough as 87% on room air." Toxygen saturation in oxygen. In addition, had not been admir In response, R2's padmitted directly to transport. During in DON stated F-A had morning of 2/19/16, about R2's condition family was first mad received the physician family was first mad received the physician the pharmacy. When interviewed of physician recalled to 2/16/16 or 2/17/16 and Azithromycin for R2 physician confirmed with administering the monitor for any allegation.	ge 26 Indicating the medication was red, and for staff to monitor for The DON stated R2 was on 2/17/16, due to her oxygen asuring 70% on room air espiratory infection]. There imentation in the medical eruse of the Azithromycin until DON conducted a physical and subsequently faxed to the ing: R2 had "a hoarse voice, and very diminished, with middle lung lobes." In icated R2 had a "tight and oxygen saturation measure The fax indicated R2's improved to 90-91% when on the fax identified the antibiotic instered as ordered 2/17/16. The hospital via ambulance terview with the DON, the dibeen at the facility on the and had expressed concerning. The DON verified that R2's de aware that R2 had not it ian ordered antibiotic at that ed, "the ball was dropped" on on for R2 and being persistent on 3/8/16, at 1:32 p.m. R2's the facility faxing him on either asking about administering the distribution of the physician ording further until 2/19/16	2 830	BELLIOITY		

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	N LIVINGCENTER - SL	AYTON	WOOD AVE I, MN 56172	NUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 830	antibiotic had not be stated after F-A had staff had contacted been assessed with sputum, and diminitation. The physician furth having prescribed to as an outpatient, and attributed to Rafive days to treat her to the following program R2's medical records. The following program and noted results when lying down. Repisodes with eden signs) obtained and stethoscope and not left lobes sounded feeling ill. Fax sent daughter to be notificated in the following report in the docum residents conditionally had also report in the docum residents conditionally had als	een started. The physician d contacted him, the facility him to inform him R2 had a hoarseness, thick yellow shed to no air flow mid lobes. er stated the rationale for he antibiotic was to treat R2 and the facility's failure to ster the prescribed antibiotics 2 requiring hospitalization for er respiratory symptoms.	2 830				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00915	B. WING	· · · · · · · · · · · · · · · · · · ·	03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SI	AYION	DWOOD AVEI N, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 28	2 830			
		mg (milligrams) po (orally) w and to check with Dr on				
	the progress notes returned from seein were for Azithromyong daily x 4 days. pharmacy). They residnet had an allocheck with Doctor. stating start & mon again faxed to (nar Thursday morning see what was happed I sent it last night, wout on that evening cart to be put in Marecord) once the medium E-kit (emergency notes in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord) once the medium seeing cart to be put in Marecord once	occumented on the back side of included, "On 2/16, residenting Drat clinic. New orders cin 500 mg first dose then 250 Order was sent to (name of returned the order stating ergy to this medicine & double Resent to Dr& returned itro for reaction. This was me of pharmacy). On (name of pharmacy) calls to be promise that it would be sent your order was left on med AR (medication administration redicine arrived. The EDU medication kit) was checked for d, & had only had one pill of				
	C-Pap per self thro saturation @ (at) 4 air). Applied PRN c L.(liters) Neb (nebu	a.m., "Resident removed bughout night. Oxygen :30 a.m. was 70% RA (room oxygen via nasal cannula @ 4 ulizer) treatment completed. to 96%. Oxygen saturation at 4 L oxygen."				
		B p.m. "Fax returned from mycin as ordered & monitor for harmacy) notified.				
	wt (weight) not don	11 a.m, "Res (resident) ill today e." A subsequent notation at d, "resident's family member in				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - SL	AYTON		NUE SOUTH		
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	, MN 56172	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 29	2 830			
	medications. Disco started r/t allergy co daughter discovere intolerance not a tru this am (morning) a 2/18/16. Pt has a r cough, very dm (dir mid lobe down no r clear. Resident sats oxygen. Resident fi sat drops to 87-889 dyspnea and denie Appears ill looking.	oncerns regarding resident vered antibiotic had not been oncern. Upon visiting with d allergy to erithromycin is an ue allergy. Zithromycin started and prednisone started on loarse voice, congested tight minished) lung sounds from eal air flow heard. Upper lobes a 90-91% with 2 liters of requently removes oxygen and 6. does not appear to have s shortness of breath (sob). Temp 99.9 Fax sent to information) and daughter				
	daughter about fax sounds, low grade oxygen on. Discuss breath) at this time have pneumonia di would need to see wants to just see he resident can be see	1 a.m. "called and spoke with to doctor, discussed lung temp and resident not leaving sed she is not sob (short of Daughter asked if she may scussed it is possible but a doctor to determine this. She ow it goes for now. Discussed en at clinic if she changes her to (pharmacy name) to inform				
	"1330 (1:30 p.m.) Note to admit to hospital in agreement- Fax ambulance. Ambul	4 p.m. the notes included, MD returned faxed with orders . Daughternotified et (and) sent to transfer per lance notifiedDaughter here red at 1400 (2 p.m.)"				
	practical nurse (LP) the message from	3/08/16, at 3:19 p.m. licensed N)-A stated she had received the pharmacy regarding R2's voin and had sent a fax to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	10/2016
-	PROVIDER OR SUPPLIER	AVTON 2957 RED	DRESS, CITY, S WOOD AVEN I, MN 56172	TATE, ZIP CODE IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	physician related to During review of R2 verified LPN-A had 2/16/16 to inform the allergy. However, the clinic after hours what the there was no reconstructed in the she'd sent the fax to provider because it physicians did not I concerns when it we further clarified she the fax to an on-cal was aware the physicians did not I concerns when it we further clarified she the fax to an on-cal was aware the physician thave contacted the different medication pharmacy would not physician. The phase facility could have contacted the different medication pharmacy would not physician. The phase facility could have contacted the wanted to go ah and the pharmacy would not physician send the he wanted to go ah and the pharmacy would not physician send the head in the pharmacy would not physician send the head wanted to go ah and the pharmacy would not physician send the head wanted to go ah and the pharmacy would not physician send the head wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the wanted to go ah and the pharmacy would not physician send the physician send the physician send the physician send	of the concern about the allergy. It is medical record it was sent a fax to the clinic on the physician of the resident's the fax had been sent to the chile the clinic was not open, response to the fax until mately 4:00 p.m. as progress notes. LPN-A stated to the clinic versus an on-call had been her experience," like to deal with patient as not their patient." LPN-A had not considered sending I physician. LPN-A stated she sician would probably not get owing day. On 3/8/16, at 1:47 p.m. the not stated the facility should physician to identify whether a not would be appropriate as the of typically contact the remacy consultant stated the questioned the use of an ion and should have had the pharmacy an order to indicate ead and use the Azithromycin, would have filled the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED		STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	received the medical prescribed by the point (F-A) hadn't brough attention she was not taken care of. F-A received the medical the hospitalization of prevented. When interviewed of LPN-B stated she reabout the Azithromy morning [2/13/16] and an allergy but a least of the physician to inform alert to the prescrib pharmacy declined the physician. The clinical the fax was sent, the antibiotic to treat Rastaff finally received that the Azithromyomedication was still additional two days declining respirators antibiotic had been least on moved her head and to be in pain. When reported experienci shoulders. R32 stascheduled pain med which helped with the sent care of the prescribed with the prescribed w	ation (Azithromycin) as hysician. F-A stated if she t the concern to the DON's ot sure it would have been eiterated that if R2 had ation as ordered, she (F-A) felt could potentially had been on 3/10/16, at 12:35 p.m. ecalled having asked F-A vcin allergy for R2 on Saturday and F-A identified there was an intolerance instead. promptly contact R2's him of the identified allergy ed Azithromycin. When the to fill the prescription without roval, in lieu of contacting the taff sent a fax to the resident's c was closed for the day when erefore intiation of an 2's URI was delayed. When a notice from R2's physician in should be administered, the not administered for an R2 was hospitalized due to a y status, URI, for which the	2 830			

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AND BLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00915	B. WING		03/	10/2016	
NAME OF PROVIDER OR SUPPLIES GOLDEN LIVINGCENTER - S	SLAVTON 2957 RED	DRESS, CITY, S DWOOD AVEN I, MN 56172	TATE, ZIP CODE NUE SOUTH			
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
assessment dated cognition, extensit transfer, walk in rounit, dressing, and assessment furthe frequent pain and medication regime. R32's care plan diagnosis (dx) of ganormally excessive cervicalgia (neck migraines, h/o chi (R) arm/shoulder/and pain below bi included pain asseneded), and to main/discomfort. The signed physic included: Tramactimes a day for pain gevery 6 hours and acetaminophe pain rated 5-9 out. The physician province included: "At presof pain in that right the old CVA (ceremay be related to occurred in that right present, we will coand see how she controlled at present."	nimum Data Set (MDS) If 2/26/16, indicated intact we assistance with bed mobility, com/corridor, locomotion on If personal hygiene. The er indicated R32 experienced was on a scheduled pain en. Interest and discomfort related to (r/t) generalized pain, kyphosis sive rounding of the back), cain), history of (h/o) chronic conic complaints of (c/o) right meck pain, h/o abdominal pain ateral knees. Interventions ressment quarterly and prn (as resionitor and report signs of Italian orders dated 2/22/16, of HCI 50 milligrams (mg) three in; acetaminophen [Tylenol] 325 prn for pain rating 1-5 out of 10; ren 650 mg every 6 hours prn for of 10. Igress note dated 2/22/16 rent, she still complains of a lot that arm, which may be related to provascular accident/stroke) or the arthritic changes that have got shoulder and arm. At continue to keep an eye on this does with it; indicates that it is	2 830				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00915	B. WING		03/1	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	WOOD AVEI , MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	her listening to the at that time, R32 sta and felt "out of plac rating of "8" out of 1 light to request to stassistant (NA)-B en later and R32 reque practical nurse (LPI experiencing in her room to alert the number of the composition of the	television. When interviewed ated her right arm was hurting e"; R32 expressed a pain IO. R32 then activated her call peak to the nurse. Nursing stered the room a short time ested to speak to licensed N)-B about the pain she was right arm; NA-B exited R32's	2 830			
	room and questioned the (R) arm pain. For hurting and that she R32 then exhibited (R) arm; the arm reshe was able to particular this had only therapist had done place. LPN-B indicates the place of the place of the place.	o.m. LPN-B entered R32's ed the resident pertaining to R32 stated her upper arm was e couldn't extend it out straight. how far she could stretch her mained bent at the elbow and tially extend the forearm. R32 happened once prior and the something to put it back into cated being unaware R32 had past and explained that				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X MULTIPLE CON A. BUILDING:	ISTRUCTION (X3) DATE SURVEY COMPLETED
00915 B. WING	03/10/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE.	ZIP CODE
2957 REDWOOD AVENUE	
GOLDEN LIVINGCENTER - SLAYTON SLAYTON, MN 56172	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
therapy staff were no longer in the building. LPN-B further indicated nursing staff was not qualified to attempt to put her arm back into place. LPN-B offered R32 prn Tylenol (acetaminophen) to see whether it would help and reassured her if the pain continued the doctor would be notified. R32 was agreeable to trying the prn (as needed) Tylenol. LPN-B exited the room; without assessing R32's pain according to the pain scale 1-10. On 3/9/16, at 2:51 p.m. LPN-B returned to R32's room with the prn Tylenol. As LPN-B was administering the medication to R32 the surveyor asked LPN-B what dosage the resident was receiving. LPN-B stated the Tylenol was 650 mg. LPN-B then asked the resident if she could rate her pain on a scale of 1-10; R32 rated her pain an 8 out of 10. LPN-B stated they would try this first and exited the room. The assessment of pain was not completed prior to the administration of the prn medication. Review of the electronic medication administration record (eMAR) indicated R32 received acetaminophen (Tylenol) 650 mg on 3/9/16, at 2:46 p.m. which was ineffective; the eMAR did not indicate a pain rating at the time given. Review of the progress notes dated 3/9/16 at 2:46 p.m. indicated R32 received acetaminophen 650 mg prn for pain rated 5-9 out of 10; the note did not indicate the resident's stated pain level. The progress note dated 3/9/16, at 15:31 (3:31 p.m.) indicated the prn administration was ineffective. The progress notes did not include a site/description of R32's pain, the resident's rating of the pain at the time of administration nor any follow-up or non-pharmacological interventions attempted with	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AYTON 2957 REI	DORESS, CITY, S DWOOD AVEN N, MN 56172	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Further review of the indicated R32's schetimes a day did not 4:00 p.m. dose. The scheduled Tramado of 9 out of 10 at the When interviewed director of nursing administration/chardirectly linked from progress notes and of the resident's pashe would expect cof the resident's pashe was experiencistating, "No, becauturther stated having when in the dining is staff, the nurse administrated she continue as yesterday, statinat the elbow and the	the eMAR dated 3/9/16, meduled Tramadol 50 mg three include a pain rating for the epain rating for the epain rating for the 8:00 p.m. of dose indicated a pain rating etime of administration. On 3/9/16, at 6:30 p.m. the (DON) confirmed that ting of prn medication is the eMAR to the electronic should include a 1-10 rating in. The DON further stated harting to include the location				
	about her (R) arm t administered the so Review of the eMA R32 was given sch	oday when she was cheduled pain medication. R dated 3/10/16, indicated eduled Tramadol 50 mg at in rating of 8 out of 10 at time				
	confirmed giving R3 Tramadol, and furth c/o back and (R) ar	on 3/10/16, at 11:58 a.m. RN-B 32 the scheduled 8:00 a.m. her confirmed the resident had m pain rated 8 out of 10 at ated the resident usually				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	10/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	DWOOD AVEN N, MN 56172	IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	always reported sor scheduled Tramado 10. RN-B stated the 9 last night were not RN-B stated R32 all use between scheduled pain administering pring document a chart nonly rated the pain scheduled pain medication. When interviewed of LPN-B confirmed she would progress note pertains 3/9/16 and should have been progressed to her knowledge with confirmed the pain to her knowledge with confirmed the pain to her knowledge with could recall the resist past. LPN-B again pain should have been she had communicated by the medications to includ documented by the the medication was assessment/locatio rating, and follow up.	me pain when given the of but usually rated 4-5 out of e rating of 8 this morning and at typical (higher) for R32. Iso had prn Tylenol available to luled doses of Tramadol for RN-B stated when nedications, she would note related to the pain, but when administering the dication (Tramadol). RN-B Id not necessarily document a ain for the scheduled on 3/10/16, at 12:10 p.m. he had not documented a aining to R32's (R) arm pain or have done so. LPN-B further R32 described in the (R) arm as unusual as no other staff ident c/o this sort of pain in the confirmed R32's c/o (R) arm een documented even though ated the information during on 3/10/16, at 1:20 p.m. the ewould expect prn ude a progress note nurse indicating the reason given, an of the pain, pain scale pr/t to effectiveness.				
		rentions using a pain based on patient/resident				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00915	B. WING	· · · · · · · · · · · · · · · · · · ·	03/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYION)WOOD AVEI I, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	cognitively impaired assessment and immedication. Evaluate recorded in a concicare. Nursing staff pain evaluation and available." Under Mincluded: "Docume care and treatment pain levels and inteand non-pharmaco will be reflected on notes." SUGGESTED MET The Director of Nurdevelop, review, and procedures to ensure conditions are concincluding medication directed. The Director could educate all and procedures. The designee could devensure ongoing consure ongoing consure ongoing consure consumer con	tive assessment for the d. Documenting pain terventions prior to giving ation activities should be se manner per the plan of should utilize the electronic I nursing note link when it is MONITORING/COMPLIANCE entation and observation of reflects ongoing monitoring of reventions (pharmacological logical). The documentation the eMAR and progress THOD OF CORRECTION: sing or designee could ad/or revise policies and are assessment of resident ducted, and that interventions ns, are implemented as tor of Nursing or designee oppropriate staff to the policies are Director of Nursing or relop monitoring systems to	2 830			
2 860	Proper Nursing Car Subp. 2. Criteria fo	or determining adequate and	2 860			4/15/16
	adequate and prop E. per care and att	riteria for determining er care include: ention to hands and feet. nails must be kept clean and				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	DWOOD AVE N, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 38	2 860			
	by: Based on observati review the facility fa of 3 residents (R1) living (ADLs). Findings include: On 3/7/16, at 11:11	ent is not met as evidenced on, interview, and document tiled to provide nail care for 1 reviewed for activities of daily a.m., and 3/8/16, at 2:09 p.m.		Corrected		
	fingernails with dark	n his room with long, jagged of brown debris noted ernails on both hands.				
	in bed while in his relong, jagged fingern present under the national fingernails were long facility had a class as where they soak the also file/trim and purasked whether staff in between and he whether he would a	p.m. R1 was observed lying oom and continued to have nails with brown residue nails. R1 confirmed his g and soiled and stated the approximately once a week e nails to clean them and will at polish on the nails. When f offer to clean his fingernails responded, "no." When asked allow staff to clean and trim his ponded affirmatively.				
	assessment dated a Interview for Menta score of 14, indicated also identified that I assistance with perdated 3/1/16, identiwith interventions in care".	num data set (MDS) 2/26/16, included a Brief I Status (BIMS) assessment ting intact cognition. The MDS R1 required extensive sonal hygiene. The care plan fied an alteration in self care ncluding: "assist with nail				
	Review of R1's eTA	R (electronic treatment				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
			71. BOILDING.			
		00915	B. WING		03/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AVTON	WOOD AVE , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 860	included: "clean, tr the 15th & 30th of a morning every 14 d When interviewed on nursing assistant (Noresponsible for trim diabetic. NA-A con- cleaning R1's nails cooperative with as When interviewed of director of nursing of responsible for resi- licensed nurses we R1's nails. The DC be cleaning R1's nails as necessary, fingernails with sur- long and soiled. Do expected R1's nails staff per the eTAR month) and would hand file R1's nails as SUGGESTED MET The DON could ins as to their responsi- residents with assis to facility policy. The	rd) dated March 2016 im and file finger and toe nails every month. [sic] in the lay(s)." on 3/10/16, at 10:50 a.m. NA)-A stated the nurses were ming R1's nails as he is firmed the NA's assist with in between and that R1 was esistance with ADL's. on 3/10/16, at 1:30 p.m. the (DON) confirmed NA's were dent nail care and that the ere responsible for trimming on verified the NA's should still ails and also could file R1's DON observed R1's east of the world by nursing (trim on 15th and 30th of each have expected NA's to clean as needed per the plan of care. THOD OF CORRECTION: ure that staff are re-inserviced bility to provide dependent stance with nail care according to being provided as indicated	2 860			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			4/15/16

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE NUE SOUTH		
GOLDEN	I LIVINGCENTER - SL	ΔΥΙΟΝ	I, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	0 Continued From page 40		2 900			
	comprehensive rest of nursing services development of a nursing services development of a nursing services. A. a resident who without pressure sores unlecondition demonstrate authenticates, that is a resident wurseleves necessary promote healing, pressure services of the services of t	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	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 necessary care and services to reduce the risk of development and/or deterioration of pressure ulcers for 2 of 4 residents (R43, R5) reviewed who were identified at risk for pressure ulcer development and had facility acquired pressure ulcers. The failure to assess and monitor the progression of the wounds to ensure appropriate interventions could be implemented, resulted in harm for R43 and R5. Findings include: R43 was admitted on 12/28/15, with diagnoses listed on his active care plan including: Anemia, depression, anxiety, vertebral fractures, repeated falls and heart failure. In addition, the record			Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - SL	AYTON)WOOD AVEN I, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	services 2/15/16 re liver cirrhosis. During interview wit on 3/7/16 at 10:39 a Stage III pressure uloss. Subcutaneous tendon or muscle is present but does no loss) which had dewide had been a sees that the admission Miniassessment dated Brief Interview for Market identified R43 requimobility and dressing transfers and did not identified R43 with incontinence and a defined area of perspigmented skin). Progress notes door record identified the sees of perspigmented skin. Progress notes door record identified the sees of perspigmented skin. Progress notes door record identified the sees of perspigmented skin. 12/31/15 Resider Small (1 centimeter coccyx; foam dress time. Will continue sees time. Will continue sees time. Will continue sees time. Will continue sees to see a se	lated to diagnosis end stage th the registered nurse (RN)-A a.m., RN-A stated R43 had a alcer (Full thickness tissue is fat may be visible but bone, is not exposed. Slough may be not obscure the depth of tissue veloped to the sacral region sident at the facility. Imum Data Set (MDS) 1/2/16, identified R43 with a Mental Status (BIMS) score of cognition. The MDS also ired extensive assist with bed ng, was dependent of staff for not ambulate. The MDS further frequent bowel and bladder Stage I pressure ulcer (a sistent redness in lightly eumented in R43's medical e following: at has redness on buttocks. (cm) x 1.5 cm) opening on ing in place. Superficial at this	2 900			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00915		B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYION		NUE SOUTH		
040.15	CLIMMA DV CTA		, MN 56172	DROVIDERIO DI ANI OF CORRECTI	ONI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 42		2 900			
	with all ADL's (activities of daily living) - unable to do anything per self at this time.					
	(nursing assistants open areas noted whave broken open, dressing applied, si	n. called to room by NAs) - resident's coccyx has two which started as blisters that tegaderm foam adhesive taff will reposition resident to in bed. Will fax doctor is a holiday.				
	-1/4/16, at 1:28 p.m. visited with resident about refusing to get out of bed frequently and need to be repositioned frequently to prevent further breakdown and pneumonia.					
	-1/5/16 Fax receive tegaderm to open a	d with order to place a areas on coccyx.				
	-1/11/16, at 2:49 p.m. dressing changed on coccyx area, no improvement noted in area. Continues to need extensive assist with repositioning, dressing, grooming, set up & eating meals,					
	ulcer on his right (F admission, that has include an air overli- pressure relieving of check and change and cleanliness, so	a.m. has history of a pressure (a) elbow during prior facility is healed. Current interventions ay mattress on his bed, a cushion on his geri-chair, a program for optimal dryness heduled turning/repositioning and use of air filled pressure oth legs/feet.				
	members with care pain issues. Tegade staff changes that of	o.m. Requires assist of 2 staff is and with repositioning due to erm in place to coccyx and in day. Requires total assist th cares. Is repositioned q 2				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SI	AVION	DWOOD AVEI N, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 43	2 900			
	hours due to press	ure area.				
	ADLs. Difficult to di Incontinent of bowe	o.m. Total dependence with all ress related to shoulder. el and bladder. Area on coccyx guineous drainage. Buttocks				
	therapy, occupation x/week for strength excoriated and tend	Receives PT/OT/ST (physical nal therapy, speech therapy) 5 lening. Coccyx area is very der, Carona (non-stick gel Will continue to monitor.				
	-1/28/16 3:46 p.m. spoke with family regarding resident having breakdown to sacral and coccyx area. Informed fax has been sent to request Propass (a protein supplement) and repositioning/offloading every 1 hour. Has low air loss mattress on bed and air boots to feet. Receives supplements bid (twice daily). Pt has denied pain today.					
	concern with poten integrity related to a communication def dribbling/incontiner cirrhosis of the live appetite/intakes, hi breakdown, history with a stage I cocci interventions include on bed, (2) pressu geri-chair, (3) Brad decub (decubitus u Encourage food & to be up & as active a report signs of skin	an for R43 identified: skin tial for alteration in skin weakness, cognitive ficit, urinary nce, bowel incontinence, r, edema, anemia, decreased story moisture associated skir of pressure ulcers, admitted yx decubitus. Care Plan led: (1.) Air overlay mattress re relieving cushion in en scale quarterly, (4) Daily elcer) monitoring, (5) fluid intakes, (6) Encourage to spossible, (7) Monitor and breakdown, (8) Provide ntinent episodes, (9) Skin				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED	DRESS, CITY, S DWOOD AVEN I, MN 56172	STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	(assessment of the tissue to prolonged altered skin site per (12) Turn/reposition and (13) Weekly de During observation B and NA-C entere provide incontinent rolled onto his left shave a 4 x 4 foam a sacral area, and two above the sacral area stated they were not the wounds as the R43 onto his side was treatment to the worepositioned hourly NA-B also stated a to feed R43 lunch shis recliner prior to R43 was noted to help protectors on. R43's current physistreatments that incl. Calcium alginate following wound cleased and the ship resident is scratching. Bilateral air filled all times, except for 4. Turn/reposition and During observation.	A, (10) Tissue tolerance testing tolerance of the resident's pressure), (11) Treatment to M.D. (medical doctor) order, and/or off-load every hour, ecubitus update on 3/9/16, at 10:38 a.m. NAdd R43's room to reposition and se care for R43. R43 was side by NA-B and was noted to dressing located over his o 2 x 4 non-stick dressings ea. NA-B and NA-C stated is under each dressing and of aware of the characteristics hey were usually positioning while the nurse was providing bunds. NA-B stated R43 was due to his declining condition. hospice aide usually came in so they would get R43 up into lunch. During this observation, have an air bed and bilateral dictant orders identified uded: with silver wound dressing eanser then cover with revery 5 days and PRN; of area on right hip where any, change as needed; pressure relieving boots on at rebathing; and/or off-load every one hour.	2 900			
		ed nurse (RN)-A and licensed N)-B performed wound cares.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON		NUE SOUTH		
	OLIMANA DV. OTA		, MN 56172	DDOUIDEDIO DI ANI OF CODDECTI	ON!	0.5
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 45		2 900			
	over his coccyx reg above the foam dre The 4 x 4 dressing dressing was noted also noted to have (Partial thickness lo shallow open ulcer without slough. May open/ruptured bliste PU of golf ball size his lower sacrum a pressure above the	ave a large foam dressing ion and two 4 x 4 dressings essing on his sacrum region. directly above the foam I to have drainage. R43 was a quarter sized Stage II PU is sof dermis presenting as a with a red-pink wound bed y also present as an intact or er) on his coccyx, a Stage III circumference, a wound on and a dime sized Stage II is sacral ulcer. RN-A cleansed ound cleanser and re-applied bunds.				
	R43's Minimum Data Set (MDS) assessments identified R43 with the following pressure ulcers: -admission assessment dated 1/2/16, identified (1) Stage I PU; -14 day assessment dated 1/9/16, identified (1) Stage I PU; -30 day assessment dated 1/23/16, identified (1) Stage I PU; -Significant change assessment dated 2/25/16, identified (1) Stage III PU.					
	record were incomp did not correlate with the wound evaluation. The following was rassessments:. (1.) 1/14/16- identiff wounds. (2.) 1/21/16- identiff no details of charaction (3.) 1/28/16 -identiff flowsheet identified.	sessments documented in the plete and/or inaccurate as they the the MDS assessments and on flowsheet documentation. Noted on the weekly skin sed coccyx- no description of sed open areas on coccyx but oteristics. Sed skin intact; (wound unstageable and Stage I) and a large open area on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - SL	ΔΥΤΟΝ	WOOD AVE			
		SLAYIO	N, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 46	2 900			
	coccyx; multiple ope and dressings in pla	en areas on bilateral buttocks; ace.				
	Flowsheet", initiated 11.5 centimeter (cm pressure area on hi evaluation dated the identified R43 with a measuring 1.0 cm. There was a discrete evaluation flowsheet nursing progress not revealed inconsiste condition of R43's secondition of R43's secondition.	racking,"Wound Evaluation d 1/28/16, identified R43 with a n) x 5 cm unstageable is coccyx and another Wound e same date 1/28/16, a second Stage I PU, x 1.5 cm on his left buttocks. pancy between the wound ets documentation and the otes. The documentation in assessments of the skin. A 3rd PU located on identified on 3/9/16, which 1.0 cm.				
	The second wound identified on R43's sacrum evaluated on 1/28/16, measured 1 cm x 1.5 cm wound was not re-evaluated again until 3/4/16, when it had increased in size to a 2.3 cm x 2.1 cm Stage II open pressure ulcer.					
	director of nursing (unaware that R43 h she realized there v	on 9/9/16, at 1:00 p.m. the (DON) stated she was had 3 PU's. The DON stated was some inconsistency in eulcers due to lack of training used staff.				
	facility nurse consu concerns about lice	on 3/9/16, at 3:20 p.m. the ltant verified there were ense staff's ability to measure re ulcers and stated staff ng.				
	and verified during	o.m. RN-C was interviewed morning dressing change she R43's buttocks, in the buttocks				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE	•	
		2957 RFI	OWOOD AVE			
GOLDEN	I LIVINGCENTER - SL	ΔΥΤΩΝ	N, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 47	2 900			
	crease, approximat sized open area on	ely quarter sized, a golf ball sacral region and a popped dime sized, above the sacral				
	and stated she worl or 3/3/16, but remed LPN-B identified R4 a larger sacral would above the sacral ar	a.m. LPN-B was interviewed ked with R43 either on 3/2/16 mbers R43 had 3 open areas. If and a wound on his coccyx, and, and 1 a smaller wound ea which was the same area essing change on 3/9/16.				
	On 3/10/16, at 8:33 a.m. NA-F was interviewed and stated she had worked as a NA with R43 last week and R43 had a foam dressing and two additional dressings on his back above the foam dressing.					
	wounds and identifi #1-coccyx wound in cm x 1.8 cm.; #2-s x 2 cm.; #3-addition periphery of the larg 0.8 cm x 0.6 cm.; a the larger sacral word The DON stated sh sacral or peripheral peripheral sacral word any documentation Throughout review noted there was incompleted to his long the development. The related to his long the development of reduce F	a.m. the DON measured R43 ed the following 4 open areas: a buttocks crease measured 2 acral wound measured 2.5 cm al sacral wound on the ger sacral wound measured and #4 wound located above and measured 1 cm x 1 cm. e was not aware of the supra sacral wounds. The bund had not been noted in found in the medical record. of R43's medical record it was consistent tracking, accuracy bing monitoring of pressure R43 was identified at high risk history of pressure ulcer medical record failed to wounds or show continuous R43's risk of further erioration of current pressure				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED		STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	ulcers. R43 had degreater pressure ulcaterioration and by The wound on R43 1/28/16, as a 1 cm evaluated again uniprogressed to a 2.3 ulcer. There was extended to the facility monitor the progressure ulcers as the fourth pressure R5 was admitted or hospital stay for reciside (fluid accumula diagnoses that including and the facility on 2/7 pelvic fractures and was subsequently by re-admitted to the facility on 2/7 pelvic fractures and was subsequently by re-admitted to the facility on 2/1 assistance with bed During observations 1:54 p.m. it was not side with her head a pillow.	veloped four (4) stage II or cers since his admission to the ed to show risk for ongoing	2 900			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYION	WOOD AVEI , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 900	Continued From page 49		2 900			
	noted the sore area prior to admission in December and explained she received it from laying on her oxygen tubing.					
	licensed practical napplied treatment to wound was observed by 2 cm with a depiedges, gray wound redness surroundin observed to be a la reported was soft wild not measure the was no longer a blist On 3/9/16, at 7:12 psleeping in her recl	o.m. R5 was noted to be iner with the foot rest raised;				
	no heel boot was evident nor were her feet elevated on a pillow. Review of the Health Status form: Skin assessment dated 12/11/15, documented no					
	1/22/16, identified In blistered area on le measured 4 cm by had previously been notification was ser When reviewing the R5's skin was ident redness until the 1/identified on the left progress notes. In note dated 1/26/16, on left side of butto and oozed serosan	e progress notes dated R5 as having a dark reddened ft side of buttocks which 2 cm, was tender to touch and in treated with barrier cream. A note to the physician on 1/22/16. It weekly skin assessments, ified as intact with no areas of 26/16, even though it was to buttock as noted in the nurse contrast, the nurse progress indicated that a blistered area cks appeared to have popped guineous drainage (watery ut no measurement taken.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00915	B. WING		03/1	0/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED	DRESS, CITY, S WOOD AVEN I, MN 56172	STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	2/2/16, indicated ar healing slowly but in physician made a coordered a foam teg wound to be chang needed. Review of the week 2/23/16, indicated a covered with patche area on the left hee Review of the nurse indicated the dress and had increased also noted that wouldark center. R5 indicated R5 and right ear (no mfurther reassessme in the record nor which were buttock and right ear (no mfurther reassessme in the record nor which acquired and were buttock and right ear (no mfurther reassessme in the record nor which was sent to the light ear (no mococcyx, the blister on back of less would not be considered and were buttock and right ear (no magnificated and were buttock and right).	In the second se	2 900			
	ear was a Stage II, touch. Review of the week	ear wound evaluation noted the open, painful and tender to all skin assessment dated ben area on buttocks only, not				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MIN 56172 PREFIX TAG SUMMARY STATEMENT OF PECFEDE BY FULL PRIEFING MIS THE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 51 measured. No mention of the ear and/or condition of the heels. Review of the Health Status form: Skin Assessment dated 2/11/16, (date of re-admission) indicated R5 had a pre-existing coccyx wound that measured 1 cm by 2-4 cm and a superficial skin scrape on back of left healed that measured 2 cm by 2 cm. Review of the admission Minimum Date Set (MDS) assessment dated 2/17/16, indicated the pen left buttock wound. Review of the admission Minimum Date Set (MDS) assessment dated 12/18/15, indicated that R5 was at risk of developing pressure ulcers and resident was independent with supervision for activities of daily living (ADLs). The significant change MDS dated 2/18/16, indicated there were no pressure ulcers and resident was at risk for developing pressure ulcers. The Brief Interview for Mental Status (BIMS) for all MDS assessments indicated R5 was cognitively intact. Review of the Braden scale for predicting PU risk dated 12/11/15, indicated R5 was cognitively intact. Review of the Braden scale for predicting PU risk dated 12/11/15, indicated R5 was cognitively intact. Review of the Braden scale for predicting PU risk dated 12/11/15, indicated R5 was cognitively intact. Review of the Braden scale for predicting PU risk dated 12/11/15, indicated R5 was at risk for developing pressure sores. The Braden scale completed on 2/17/16, indicated R5 was at risk for developing pressure sores. The Braden scale completed on 2/17/16, indicated R5 was at risk for developing pressure sores. The Braden scale completed on 2/17/16, indicated R5 was at risk for developing pressure sores. The Braden scale completed on 2/17/16, indicated R5 was at risk for developing pressure sores. The Braden scale completed on 2/17/16, indicated R5 was at risk for de		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
CALL DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES FACE DEFICIENCY MUST BE PRECEDED BY FULL FACE DEFICIENCY OR ISC IDENTIFYING INFORMATION) PREFIX FACE DEFICIENCY OR ISC IDENTIFYING INFORMATION) PREFIX FACE DEFICIENCY OR ISC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE DATE			00915	B. WING		03/	10/2016
SUMMARY STATEMENT OF BETICENCIES PROVIDERS PLAN OF COORDECTION PROVIDERS PLAN OF COORDECTION PREFIX TAG PROVIDERS PLAN OF COORDECTION PROVIDERS PLAN OF COORD	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 51 measured. No mention of the ear and/or condition of the heels. Review of the Health Status form: Skin Assessment dated 2/11/16, (date of re-admission) indicated R5 had a pre-existing coccyx wound that measured 1 cm by 2.4 cm and a superficial skin scrape on back of left healed that measured 2 cm by 2 cm. Review of the Health Status form: Skin Assessment dated 2/11/16, did not note the open left buttock wound. Review of the Health Status form: Skin Assessment dated 2/17/16, did not note the open left buttock wound. Review of the admission Minimum Date Set (MDS) assessment dated 12/18/15, indicated that R5 was at risk of developing pressure ulcers but did not any when admitted. The discharge/return anticipated MDS dated 2/7/16, indicated there were no pressure ulcers and resident was independent with supervision for activities of daily living (ADLs). The significant change MDS dated 2/18/16, did not indicate a presence of pressure ulcers and required extensive assistance with ADLs. The associated Care Area Assessment (CAA) indicated resident was at risk for developing pressure ulcers. The Brief Interview for Mental Status (BIMS) for all MDS assessments indicated R5 was at risk for developing pressure users. The Braef leneries was at moderate risk for developing PU and there was no indication that resident had an existing PU prior to and after hospitalization. Review of the Tissue tolerance observance was	GOLDEN	I LIVINGCENTER - SL	AYTON				
measured. No mention of the ear and/or condition of the heels. Review of the Health Status form: Skin Assessment dated 2/11/16, (date of re-admission) indicated R5 had a pre-existing coccyx wound that measured 1 cm by 2.4 cm and a superficial skin scrape on back of left healed that measured 2 cm by 2 cm. Review of the Health Status form: Skin Assessment dated 2/17/16, did not note the open left buttock wound. Review of the admission Minimum Date Set (MDS) assessment dated 12/18/15, indicated that R5 was at risk of developing pressure ulcers but did not any when admitted. The discharge/return anticipated MDS dated 2/17/16, indicated there were no pressure ulcers and resident was independent with supervision for activities of daily living (ADLs). The significant change MDS dated 2/18/16, idd not indicate a presence of pressure ulcers and required extensive assistance with ADLs. The associated Care Area Assessment (CAA) indicated resident was at risk for developing pressure ulcers. The Brief Interview for Mental Status (BIMS) for all MDS assessments indicated R5 was cognitively intact. Review of the Braden scale for predicting PU risk dated 12/11/15, indicated R5 was at risk for developing pressure sores. The Braden scale completed on 2/17/16, indicated R5 was at moderate risk for developing PU and there was no indication that resident had an existing PU prior to and after hospitalization.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
completed 12/16/15, and indicated R5's skin was	2 900	measured. No mer condition of the heer condition of the heer Review of the Healt Assessment dated re-admission) indic coccyx wound that a superficial skin so that measured 2 cm. Review of the Healt Assessment dated left buttock wound. Review of the admis (MDS) assessment R5 was at risk of dedid not any when accompleted MDS dawere no pressure up independent with suliving (ADLs). The second (CAA) indicated resideveloping pressure of the Mental Status (Eassessments indicated the second property of the Braded dated 12/11/15, indicated resideveloping pressure completed on 2/17/moderate risk for deno indication that reprior to and after how the Review of the Tissue Review of t	Intion of the ear and/or els. In Status form: Skin 2/11/16, (date of cated R5 had a pre-existing measured 1 cm by 2.4 cm and crape on back of left healed in by 2 cm. In Status form: Skin 2/17/16, did not note the open ssion Minimum Date Set dated 12/18/15, indicated the eveloping pressure ulcers but dimitted. The discharge/return ated 2/7/16, indicated there licers and resident was appervision for activities of daily significant change MDS dated icate a presence of pressure extensive assistance with ted Care Area Assessment sident was at risk for e ulcers. The Brief Interview BIMS) for all MDS ated R5 was cognitively intact. The Braden scale 16, indicated R5 was at eveloping PU and there was esident had an existing PU is espitalization.	t			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
00915 B. WING	03/10/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETE
2 900 Continued From page 52 normal after sitting and lying 2 hours; however review of the tissue tolerance observance indicated it was initiated on 2/17/16, but was the assessment never completed and documented by staff. During review of the physician orders dated and noted 3/4/16, it directed to paint right ear and heel with betadine twice daily until healed. The treatment administration record (TAR) noted the betadine treatment was started 3/5/16 and applied to the heel twice daily as indicated by nursing initials. The treatment for the right ear was not on the TAR and no documentation noted in the nurses notes that it was applied. Review of the resident's care plan initiated 1/1/16 indicated there was a potential for alteration in skin integrity. The plan and interventions included: (1) air mattress on bed and pressure relieving pad in wheelchair, (2) Assist with pericare s/p dribbling/incontinence, (3) Braden scale quarterly, (4) encourage fluids (5) monitor and report signs of skin breakdown (6) skin assessment weekly (7) tissue tolerance testing, (8) treatment to altered skin site per M.D. order. On 2/28/16 the care plan was revised to add intervention to turn/reposition and/or off-load q 2 H (every 2 hours). On 3/8/16 (one day after survey team entered facility) the care plan was revised to include intervenitions to culture pressure wounds and pressure ulcer care per M.D. order. When interviewed on 3/10/16, at 8:15 a.m. the director of nurses (DON) verified the wound assessment of R5's right ear had not been documented. DON also verified the physician ordered ear treatment was not on the treatment	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
		00915	B. WING		03/	10/2016
	PROVIDER OR SUPPLIER	AVTON 2957 RED		STATE, ZIP CODE NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	DON was unaware scabbing. She furth interventions put int from the ear while F During an interview assistant (NA)-C in turning schedule stally her down and to doing something will During an interview reported that she go before she fell [2/7/ assisted with perso was sore; they told R5 stated, "They we that's all they did. No sore and tender. It I that is why they lay During an interview verified the treatme TAR as ordered by interventions noted worksheets. The identified wounfollows: Left buttock measured to the treatme TAR as ordered by interventions noted worksheets. The identified wounfollows: Left buttock measured to the treatme TAR as ordered by interventions noted worksheets.	the ear was open with bloody er verified there were no to place to relieve pressure R5 was lying in bed. on 3/8/16, at 1:12 nursing edicated R5 was not on a lating "she lets us know. We silet when she asks. We are the her 6 times a day". 3/9/16, at 1:00 p.m. R5 of the sore on her bottom long 16]. R5 stated that when staff nal care she informed them it her she had an open area. Fould put some cream on it and low its covered. It's still pretty furts to sit on it too long so me down often". on 3/9/16, at 7:04 p.m. DON nt was not documented on the the physician nor were on the care plan and aid and ulcers were documented as rements (identified 1/22/16): m, width 2 cm, no depth ea; width 1 cm; aluation week 1: 2.4 cm, width uge I uation wk 2: length 2 cm, width	2 900			
	Heel measurement 3/3/16-length 2 cm.	s (identified 2/23/16): width 2.5 cm.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYION	WOOD AVEI I, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 54	2 900			
	Throughout review noted there was no of reporting nor ong when R5 was ident development. The ridid not accurately a the wounds nor or of monitoring to reduce development or detulcers. The Weekly Skin Ridirects skin alteration the figures provided and location. It furth flow was to be initiated to be notified and cowith new intervention pressure ulcer was	of R5's medical record it was a consistent tracking, accuracy going monitoring of PU's even offied at high risk for PU medical record documentation and consistently identify all of did it demonstrate continuous e R5's risk of further erioration of current pressure eview policy dated 5/1/15, on findings to be identified, use d, describe type of alteration and directs a wound evaluation are directs a wound evaluation are plans were to be updated ons. A policy related to requested and not submitted.				
	on 1/26/16 as an open and not evaluate had progressed to a pressure ulcer. The harm related to the	left coccyx was documented ben blistered area 4 cm by 2 ed again until 3/3/16, when it a 2.5 cm x 2 cm open are was evidence R5 sustained facility's failure to accurately the progression of identified				
	wounds. R5 remain further pressure uld development of the pressure ulcer. SUGGESTED MET	ed at risk for development of				
		ure to ensure residents have ssessment of their risk for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7 IVD I LAIV	OF COMMEDITION	DENTIFICATION NOMBER.	A. BUILDING:		OOW	
		00915	B. WING		03/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON	WOOD AVE , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900 21426	interventions could of Nursing or her de appropriate staff on related to pressure Nursing or her designation of the pressure assessed and apprimplemented, to prepressure ulcers. TIME PERIOD FOR (21) Days.	re ulcers so that individualized be implemented. The Director esignee could educate all the polices and procedures ulcers. The Director of gnee could develop a to ensure residents are opriate interventions event the development of a CORRECTION: Twenty-one	2 900 21426			4/15/16
	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of eation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY PLETED
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - SL	ΔΥΤΩΝ	DWOOD AVE N, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 56	21426			
	by: Based on interview facility failed to ensi residents (R5, R9, I	ent is not met as evidenced and document review the ure 3 of 5 newly admitted R43) had a tuberculosis (TB) g completed upon admission te guidelines.		Corrected		
	Findings include:					
	record lacked docu	n 12/11/15. The medical mentation of a completed TB g upon admission as required s.				
	record lacked docu	n 12/29/15. The medical mentation of a completed TB g upon admission as required s.				
	record lacked docu	on 12/28/15. The medical mentation of a completed TB g upon admission as required s.				
	10:00 a.m., the dire R5, R9, and R43's	on 3/8/16, at approximately ector of nursing (DON) verified TB symptom screening form not completed upon uld have been.				
	Residents for effect facility will screen re readmission for info to, or symptoms of, recent (within 12 m (TST), blood assay	aberculosis, Screening tive 12/1/14 included: "The eferrals for admission and formation regarding exposure TB and will check results of onths) tuberculin skin tests for Mycobacterium (5) or chest X-rays (CXR)."				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00915	B. WING		03/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - SL	AYION	WOOD AVE I, MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ige 57	21426			
21620	administrator, direct and revise policies surveillance. The anursing, could monto ensure ongoing of TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	21620			4/15/16
21620	MN Rule 4658.134	b Labeling of Drugs	21620			4/15/16
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.				
	by: Based on observative review the facility farmedications to ensured medications. This	ent is not met as evidenced ion, interview and document ailed to properly label and store ure safe administation of has the potential to affect any who reside in the facility.		Corrected		
	Findings include:					
	p.m. licensed pract observed preparing scheduled to receiv Symbicort inhaler d on it. LPN-B then re	ion pass on 3/9/16, at 4:22 ical nurse B (LPN-B) was medications for R2. R2 was to a Symbicort inhaler. The lid not have a medication label etrieved a new inhaler that did efore administering the				
		of the north/south cart the ns were found without labels:				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
		00915	B. WING		03/	10/2016
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOLDE	N LIVINGCENTER - SL	ΔΥΤΩΝ	DWOOD AVEN N, MN 56172	IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21620	Liquitears 1.4% eyedrops 3 bottles, Time and Lantaprost 0.00 addition, an open be drops was noted with bottle. The label or The medication was discontinued 2/8/16 Mucinex 600 mg with was evident and note that a label on it. Of LPN-B stated she of was stored in the cast know whether it was individual prescription. When interviewed a director of nursing (discontinued Oxyflothave had a label and discontinued. She should have the appresident's name. The policy PRODUP PACKAGE TYPES medication orders of are labeled in accordinate that is appropriately and shave: 1. Any labeling regulation and professions and professions in the cast is appropriately and shave: 1. Any labeling regulation and professions in the cast is appropriately and shave: 1. Any labeling regulation and professions is appropriately and shave: 1. Any labeling regulation and professions is a state of the cast is a stat	e drops 3 bottles, Systane eye holol eye drops 0.5% 1 bottle, 005% eye drops 1 bottle. In ottle of Oxyfloxin 0.3% eye th R15's name written on the nottle bottle said E-Kit 1/31/16. In ottle of Cyfloxin 0.3% eye th R15's name written on the nottle bottle said E-Kit 1/31/16. In ottle bottle said explain the card of the pills remaining in the card of the label was on the medication. In J10/16, at 10:31 a.m. In ottle bottle				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	ΔΥΙΩΝ	WOOD AVE , MN 56172	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21620	Continued From pa		21620			
	is less	le or cautionary statements				
	director of nursing or revise policies and medication labeling could be provided to	THOD OF CORRECTION: The or designee could review and / nd procedures related to requirements. Education the staff. The quality ee could develop a system to eness of the plan.				
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			4/15/16
	reporter who has revulnerable adult is lor who has knowled has sustained a phreasonably explained information to the condividual is a vulne the individual is adreporter is not required.	of report. (a) A mandated eason to believe that a peing or has been maltreated, dge that a vulnerable adult eysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior is:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572	as admitted to the facility from the reporter has reason to ble adult was maltreated in the mows or has reason to believe a a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00915	B. WING		03/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	AYTON		NUE SOUTH		
	OLIMANA DV. OTA		, MN 56172			0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 60	21980			
	provisions of this sas described above (c) Nothing in this known or suspected knows or has reason been made to the control (d) Nothing in this reporter from also reason to believe the 626.5572, subdivision. If the retime believes that a agency will determine the reported error with the criteria under set 17, paragraph (c), control (directly to the lead and thow the event mee 626.5572, subdivision). The lead ager information when met the report under such that the report under such that the subdivision is the subdivision.	ection may voluntarily report e. s section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. s section shall preclude a reporting to a law enforcement reporter who knows or has not an error under section fon 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or et to the common entry point or agency information explaining ts the criteria under section 17, paragraph (c), clause not shall consider this naking an initial disposition of				
	by: Based on interview facility failed to immadministrator and Salleged violation of	and document review, the		Corrected		
	Findings include:					
	The facility's Abuse	/Neglect policy, Vulnerable				

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :		TE SURVEY MPLETED
				•		
		00915	B. WING		03	/10/2016
NAME OF PROVIDER OR SUF	PLIER			STATE, ZIP CODE		
GOLDEN LIVINGCENTE	R - SI	ΙΔΥΤΩΝ	DWOOD AVE N, MN 56172	NUE SOUTH ?		
PREFIX (EACH DEF	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
identified neg supply a residenceded to obta health and sa care or service anguish, or manglect and madministrator. The policy idea be reported in administrator, entry point, and of Health. When interviet telephone, Rand a concern medication proposed two weeks ago of the omitteed later when Range respiratory did she had been treatment/me felt this could hospitalization primary family were aware somedical cond F-A stated Range with respirator and that R2's since this epis physician had for R2's respinadministered. When interview	tment lect a lent we tain an artifice and a central and a	t Plan updated 1/2016, s "a failure or omission to vith care or services that are nd/or maintain the resident's It includes failure to provide avoid physical harm, mental illness." The policy identified al errors as reportable to the appropriate state agencies. d allegations of neglect should	f			

Minnesota Department of Health

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Minnesc	<u>ita Department of He</u>	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00915	B. WING		03/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2957 RED		NUE SOUTH		
GOLDEN	I LIVINGCENTER - SL	AYTON	I, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21980	prescribed Azithron respiratory infection stated that after the the pharmacy to be notified facility staff an allergy for R2. Informed the physic pharmacy alert by istill to be administe allergy symptoms, started on oxygen of saturation level me. [diagnosis: upper resthere was no further in the medical reconducted a physic subsequently faxed R2 had "a hoarse wery diminished, will lung lobes." In add a "tight congested of measure 87% on rock?'s oxygen saturation oxygen. In addit antibiotic had not be 2/17/16. In response R2 be admitted direambulance transpodon, the DON also facility on the morniexpressed concern DON verified that Faware that R2 had ordered antibiotic a "the ball was dropp for R2 and being per state of the staff and being per staff and the staff a	ge 62 nycin to treat an upper (URI) [2/17/16]. The DON prescription had been sent to filled, the pharmacy had the medication was listed as The DON stated the staff had can who had responded to the indicating the medication was red, and for staff to monitor for The DON stated R2 was on 2/17/16, due to her oxygen asuring 70% on room air espiratory infection]. However, or assessment documentation or related to the use of the 1/19/16, when the DON all assessment of R2 and assessment of R2 and to the physician the following: oice, thick yellow sputum and the little or no air flow, middle ition, the fax indicated R2 had cough and oxygen saturation from air." The fax indicated the gen administered as ordered see, R2's physician ordered that eacily to the hospital via ort. During interview with the constated F-A had been at the ing of 2/19/16, and had about R2's condition. The 1/2's family had first been made not received the physician that time. The DON stated, ed" on getting the medication ersistent with the pharmacy.				
		he facility faxing him on either				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00915	B. WING		03/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN LIVINGCENTER - SLAYTON 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21980	2/16/16 or 2/17/16 a Azithromycin for R2 physician confirmed with administering t monitor for any alle stated he'd heard n when F-A contacted antibiotic had not be stated after F-A had staff had contacted been assessed with sputum, and diminis The physician furth having prescribed to as an outpatient, an acquire and adminis had attributed to R2 five days to treat he During review of R2 verified a fax had be 2/16/16 to inform th However, the fax w when the clinic was response to the fax approximately 4:00 progress notes. When interviewed of DON stated this iss the State agency ar accordance with the During interview wit (LPN)-A on 3/8/16, she sent the fax to provider because it physicians did not li concerns when it w	asking about administering the 2's respiratory symptoms. The 2'he'd ordered staff to proceed the medication and for staff to rgy symptoms. The physician othing further until 2/19/16 d him to inform him the een started. The physician d contacted him, the facility him to inform him R2 had a hoarseness, thick yellow shed to no air flow mid lobes. For example, the prescribed antibiotics are the prescribed antibiotics are respiratory symptoms. Part is medical record it was een sent to the clinic on the physician of the allergy, as sent to the clinic after hours and open thus there was no until 2/17/16 at p.m. as documented in the pon 3/8/16, at 2:23 p.m. the ue had not been reported to addor the administrator in				

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BOILDING.				
		00915	B. WING		03/1	0/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDEN LIVINGCENTER - SLAYTON 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21980	Continued From pa	ge 64	21980				
	on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day.						
	The administrator of staff are aware of the reporting. They could be a staff are aware of the reporting.	THOD OF CORRECTION: or designee could ensure all ne importance of immediate ald establish a system to audit tions are properly reported in cility policy.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one					
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			4/15/16	
	(a) Each facility shongoing written proapplicable licensing of suspected maltrefacility has an intermandated reporter requirements of this internally. Howeve	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains applying with the immediate ents of this section.					
	by: Based on interview facility failed to imp policy to ensure imi allegations of poter	and document review, the lement their Abuse/Neglect mediate reporting of thial neglect of treatment to the for 1 of 3 residents (R2)		Corrected			
	Findings include:						

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Minnesota Department of Health STATE FORM

				DATE SURVEY COMPLETED	
00915	B. WING		03/10/2016		
	RESS, CITY, S	STATE, ZIP CODE	1 00/1	0/2010	
GOLDEN LIVINGCENTER - SLAYTON 2957 REDV SLAYTON,		NUE SOUTH			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
The facility's Abuse /Neglect policy, Vulnerable Adult Maltreatment Plan updated 1/2016, identified neglect as "a failure or omission to supply a resident with care or services that are needed to obtain and/or maintain the resident's health and safety. It includes failure to provide care or services to avoid physical harm, mental anguish, or mental illness." The policy identified neglect and medical errors as reportable to the administrator and appropriate state agencies. The policy identified allegations of neglect should be reported immediately to the administrator/director of nursing (DNS), common entry point, and State of Minnesota Department of Health. When interviewed on 3/7/16, at 2:35 p.m. via telephone, R2's family member (F)-A stated she had a concern that R2 had not received a medication prescribed by her physician," about two weeks ago". F-A stated she was not informed of the omitted medication/treatment until 3 days later when R2 required hospitalization due to respiratory difficulties. F-A further explained that if she had been contacted by the facility when the treatment/medication had been prescribed, she felt this could have potentially prevented hospitalization for R2. F-A stated she was the primary family contact for R2, and the facility staff were aware she should be contacted regarding medical condition changes R2 might experience. F-A stated R2 had been admitted to the hospital with respiratory concerns, shortness of breath and that R2's health had continued to decline since this episode of illness. F-A stated the physician had prescribed Azithromycin (antibiotic) for R2's respiratory issues but the facility had not	21995				

Minnesota Department of Health

Minnesc	<u>ita Department of He</u>	<u>ealth</u>				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		COMPLETED	
		00915	B. WING		03/10/2016	
		•				0,2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - SL	ΙΔΥΤΩΝ	DWOOD AVE	NUE SOUTH		
		SLAYIO	N, MN 56172			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIVE		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
ma		,	17.0	DEFICIENCY)		
01005	Oznation and Europe	00	01005			
21995	Continued From pa	age 66	21995			
	When interviewed of	on 3/8/16 at 12:48 p.m., the				
		(DON) confirmed R2 had been				
		nycin to treat an upper				
		n (URI) [2/17/16]. The DON				
		e prescription had been sent to				
		e filled, the pharmacy had				
		f the medication was listed as				
		The DON stated the staff had				
		cian who had responded to the				
		indicating the medication was				
	still to be administered, and for staff to monitor for					
	allergy symptoms. The DON stated R2 was					
	started on oxygen on 2/17/16, due to her oxygen					
	saturation level measuring 70% on room air					
	[diagnosis: upper respiratory infection]. However,					
	there was no further assessment documentation					
		ord related to the use of the				
		2/19/16, when the DON				
		cal assessment of R2 and				
		d to the physician the following				
		voice, thick yellow sputum and				
		ith little or no air flow, middle				
		lition, the fax indicated R2 had				
		cough and oxygen saturation				
		oom air." The fax indicated				
	R2's oxygen satura	ation improved to 90-91% when	ı			
	, , ,	tion, the fax identified the				
		een administered as ordered				
		se, R2's physician ordered tha	t 🛮			
		ectly to the hospital via				
		ort. During interview with the				
		o stated F-A had been at the				
	•	ing of 2/19/16, and had				
		about R2's condition. The				
		R2's family had first been made	,			
		not received the physician				
		at that time. The DON stated,				
		· · · · · · · · · · · · · · · · · · ·				
"the ball was dropped" on getting the medication						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			DATE SURVEY COMPLETED	
	00915		B. WING		03/1	03/10/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	1 30/1		
GOLDEN	I LIVINGCENTER - SI	NUE SOUTH					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
21995	When interviewed physician recalled to 2/16/16 or 2/17/16 Azithromycin for Riphysician confirme with administering monitor for any allestated he'd heard rowhen F-A contacted antibiotic had not be stated after F-A has staff had contacted been assessed with sputum, and diminited the physician furth having prescribed to as an outpatient, and acquire and adminited attributed to Rifive days to treat her buring review of Riverified a fax had be 2/16/16 to inform the However, the fax when the clinic was response to the fax approximately 4:00 progress notes. When interviewed DON stated this issue the State agency and accordance with the During interview with the contact of the fax to provider because it	on 3/8/16, at 1:32 p.m. R2's the facility faxing him on either asking about administering the 2's respiratory symptoms. The d he'd ordered staff to proceed the medication and for staff to ergy symptoms. The physician nothing further until 2/19/16 d him to inform him the een started. The physician d contacted him, the facility I him to inform him R2 had h hoarseness, thick yellow ished to no air flow mid lobes. Her stated the rationale for the antibiotic was to treat R2 and the facility's failure to ister the prescribed antibiotics 2 requiring hospitalization for the respiratory symptoms. 2's medical record it was been sent to the clinic on the physician of the allergy. Fas sent to the clinic after hours as not open thus there was not until 2/17/16 at 1 p.m. as documented in the sue had not been reported to nod/or the administrator in					

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED		
		B. WING						
00915				03/1	0/2016			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH							
GOLDEN	N LIVINGCENTER - SL	AVION	, MN 56172					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21995	Continued From pa	ge 68	21995					
21995	concerns when it w stated she did not con-call physician. L the physician would the following day. SUGGESTED MET The administrator of staff are aware of the facility policy for Ab could establish a sy allegations are proposition.	as not their patient." LPN-A consider sending the fax to an PN-A stated she was aware a probably not get the fax until THOD OF CORRECTION: or designee could ensure all ne importance of following the use/Neglect reporting. They yetem to audit to ensure all perly reported in accordance	21995					

Minnesota Department of Health