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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7D8B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245386**

2. STATE VENDOR OR MEDICAID NO. (L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - SLAYTON**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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

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

6. DATE OF SURVEY **04/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE Nursing Ev II 05/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 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

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

MDH
Minnesota Department of Health

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).

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245386 Y1	A. Building B. Wing Y2	4/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(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 F0278	Correction	ID Prefix F0280	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	04/15/2016	LSC	04/15/2016	LSC	04/15/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	04/15/2016	LSC	04/15/2016	LSC	04/15/2016
ID Prefix F0314	Correction	ID Prefix F0431	Correction	ID Prefix	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.60(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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	05/02/2016	03048	4/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/10/2016

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

Minnesota Department of Health

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

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00915 Y1	A. Building B. Wing Y2	4/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265	Correction	ID Prefix 20555	Correction	ID Prefix 20565	Correction
Reg. # MN Rule 4658.0085	Completed	Reg. # MN Rule 4658.0405 Subp. 1	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed
LSC	04/15/2016	LSC	04/15/2016	LSC	04/15/2016
ID Prefix 20570	Correction	ID Prefix 20830	Correction	ID Prefix 20860	Correction
Reg. # MN Rule 4658.0405 Subp. 4	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 2 F.	Completed
LSC	04/15/2016	LSC	04/15/2016	LSC	04/15/2016
ID Prefix 20900	Correction	ID Prefix 21426	Correction	ID Prefix 21620	Correction
Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1345	Completed
LSC	04/15/2016	LSC	04/15/2016	LSC	04/15/2016
ID Prefix 21980	Correction	ID Prefix 21995	Correction	ID Prefix	Correction
Reg. # MN St. Statute 626.557 Subd. 3	Completed	Reg. # MN St. Statute 626.557 Subd. 4a	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 BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	5/2/2016	03048	4/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/10/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7D8B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245386**

2. STATE VENDOR OR MEDICAID NO. (L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - SLAYTON**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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

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

6. DATE OF SURVEY **03/10/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 04/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 04/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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;

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		4/15/16

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the family and physician in a timely manner for 1 of 1 resident (R2) reviewed for hospitalization who experienced significant changes in her respiratory condition requiring medical treatment. This resulted in actual harm for R2, who experienced diminished lung sounds and a congested tight cough related to delayed physician notification regarding failure to initiate prescribed antibiotic medication to treat an upper respiratory infection, with subsequent transfer to an inpatient facility for respiratory distress. Findings include: When interviewed on 3/7/16, at 2:35 p.m. via telephone, R2's family member (F)-A was questioned about notification by staff when a significant change in the resident's physical health or status occurred. 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	F 157	Golden LivingCenter Slayton realizes that promoting care for residents in a timely manner to ensure proper treatment in changes of conditions or cares. Staff have been educated on: -Golden LivingCenter Slayton's policy and procedure for timely contacting families and physician with changes in condition or cares. -On-call physician lists have been obtained by collaborating with the clinic manager to have notification of who is on call, and licensed staff is educated on utilization of on-call physician services. -On admission of residents, it is policy to attempt to identify reactions to medications listed as allergies. -The proper procedure for obtaining antibiotics and the timely administration of antibitoics.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 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 administered the medication as ordered. When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by 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]. There was no further documentation in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure	F 157	Random audits will be completed bi-monthly until July 1st with deficit practices brought to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family was first made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy.

When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms.

The following progress notes were recorded in R2's medical record:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 On 2/12/16 at 12:00 p.m., "...This nurse went into room and noted resident lying in bed audible wheeze heard. 2+ edema noted to bilateral feet. Resident has frequent non productive cough when lying down. Resident has had frequent episodes with edema to bilateral feet...VS (vital signs) obtained and lung sounds listened to per stethoscope and noise noted in right lobes where left lobes sounded diminished. Resident denies feeling ill. Fax sent to MD (medical doctor) and daughter to be notified when she comes in facility." On 2/13/16 at 5:29 p.m., family approached this nurse tor report [R2] was not waking up today and not transferring well. The note indicated the family had also reported R2 had a frequent cough. The documented note included, "Residents condition has changed this week. She has been more difficult to transfer and has had more edema to feet and more cough... Lung sounds diminished in right and sounds noted in left. Frequent cough noted. Call placed to Dr. (doctor) on call at hospital and order received for Duoneb's q (every) 4 hours prn (as needed) and for Prednisone 60 mg (milligrams) po (orally) today and tomorrow and to check with Dr... on Monday..." An undated note documented on the back side of the progress notes included, "On 2/16, resident returned from seeing Dr ...at clinic. New orders were for Azithromycin 500 mg first dose then 250 mg daily x 4 days. Order was sent to (name of pharmacy). They returned the order stating residnet had an allergy to this medicine & double check with Doctor. Resent to Dr...& returned stating start & monitro for reaction. This was	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5	F 157		

again faxed to (name of pharmacy). On Thursday morning (name of pharmacy) calls to see what was happening with order. I stated that I sent it last night, where upon she asked me to fax it again, with the promise that it would be sent out on that evening run. Order was left on med cart to be put in MAR (medication administration record) once the medicine arrived. The EDU E-kit (emergency medication kit) was checked for a supply of this med, & had only had one pill of 250 mg in stock."

On 2/17/16 at 5:37 a.m., "Resident removed C-Pap per self throughout night. Oxygen saturation @ (at) 4:30 a.m. was 70% RA (room air). Applied PRN oxygen via nasal cannula @ 4 L.(liters) Neb (nebulizer) treatment completed. Oxygen increased to 96%. Oxygen saturation at this time 98% with 4 L oxygen."

On 2/17/16, at 4:03 p.m. "Fax returned from Dr...to start Azithromycin as ordered & monitor for allergy. (Name of pharmacy) notified.

On 2/19/16, at 10:11 a.m, "Res (resident) ill today wt (weight) not done." A subsequent notation at 11:39 a.m. included, "resident's family member in to visit today, has concerns regarding resident medications. Discovered antibiotic had not been started r/t allergy concern. Upon visiting with daughter discovered allergy to erithromycin is an intolerance not a true allergy. Zithromycin started this am (morning) and prednisone started on 2/18/16. Pt has a hoarse voice, congested tight cough, very dm (diminished) lung sounds from mid lobe down no real air flow heard. Upper lobes clear. Resident sats 90-91% with 2 liters of oxygen. Resident frequently removes oxygen and sat drops to 87-88%. does not appear to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6	F 157		

dyspnea and denies shortness of breath (sob). Appears ill looking. Temp 99.9... Fax sent to Dr...with above info (information) and daughter notified."

On 2/19/16, at 11:51 a.m. "called and spoke with daughter about fax to doctor, discussed lung sounds, low grade temp and resident not leaving oxygen on. Discussed she is not sob (short of breath) at this time. Daughter asked if she may have pneumonia discussed it is possible but would need to see a doctor to determine this. She wants to just see how it goes for now. Discussed resident can be seen at clinic if she changes her mind. Call placed to (pharmacy name) to inform of allergy.

On 2/19/16, at 2:24 p.m. the notes included, "1330 (1:30 p.m.) MD returned faxed with orders to admit to hospital. Daughter...notified et (and) in agreement- Fax sent to transfer per ambulance. Ambulance notified...Daughter here et resident transferred at 1400 (2 p.m.)..."

During interview on 3/08/16, at 3:19 p.m. licensed practical nurse (LPN)-A stated she had received the message from the pharmacy regarding R2's allergy to Azithromycin and had sent a fax to the physician related to the concern about the allergy.

During review of R2's medical record it was verified LPN-A had sent a fax to the clinic on 2/16/16 to inform the physician of the resident's allergy. However, the fax had been sent to the clinic after hours while the clinic was not open, thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes. LPN-A stated she'd sent the fax to the clinic versus an on-call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 7	F 157		

provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A further clarified she had not considered sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day.

When interviewed on 3/8/16, at 1:47 p.m. the pharmacy consultant stated the facility should have contacted the physician to identify whether a different medication would be appropriate as the pharmacy would not typically contact the physician. The pharmacy consultant stated the facility could have questioned the use of an alternative medication and should have had the physician send the pharmacy an order to indicate he wanted to go ahead and use the Azithromycin, and the pharmacy would have filled the prescription.

When interviewed on 3/8/16, at 3:25 p.m. the DON and the administrator verified there should have been a more timely follow up regarding the antibiotic prescribed by the physician.

When interviewed on 3/10/16, at 9:00 a.m. F-A stated LPN-B had informed F-A on the morning of 2/19/16 while she was visiting R2, that R2 had not received the medication (Azithromycin) as prescribed by the physician. F-A stated if she (F-A) hadn't brought the concern to the DON's attention she was not sure it would have been taken care of. F-A reiterated that if R2 had received the medication as ordered, she (F-A) felt the hospitalization could potentially had been prevented.

When interviewed on 3/10/16, at 12:35 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 8	F 157		

LPN-B stated she recalled having asked F-A about the Azithromycin allergy for R2 on Saturday morning [2/13/16] and F-A identified there was not an allergy but an intolerance instead.

The facility's policy Notification of Change in Resident Health Status, revised 11/11/15, identified the facility would consult with the resident's physician, nurse practitioner or physician assistant, and family when:

A. An accident occurred which resulted in injury and required potential for physician intervention.
B. Acute illness or a significant change in the resident's physical, mental, or psychological status (i.e. deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications.
C. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. Depending on nursing assessment appropriate notification may be immediate (defined in policy as soon as possible no longer than 24 hours) to 48 hours.
D. A decision to transfer or discharge a resident.
E. expected or unexpected deaths.

The facility failed to promptly contact R2's physician to inform him of the identified allergy alert to the prescribed Azithromycin. When the pharmacy declined to fill the prescription without the physician's approval, in lieu of contacting the on-call physician, staff sent a fax to the resident's physician. The clinic was closed for the day when the fax was sent, therefore intiation of an antibiotic to treat R2's URI was delayed. When staff finally received notice from R2's physician that the Azithromycin should be administered, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 9 medication was still not administered for an additional two days. R2 was hospitalized due to a declining respiratory status, URI, for which the antibiotic had been originally ordered.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the administrator and State Agency (SA) of an alleged violation of neglect for 1 of 3 residents (R2) for whom an allegation of neglect was reviewed. Findings include: 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 administered the medication as ordered.	F 225	F225 Golden LivingCenter Slayton realizes the importance of immediate reporting of allegations of abuse to the administrator and State agency. The policy and procedure for immediate reporting of abuse allegations has been reviewed for resident #R2. To prevent further incident to other residents, re-education will be provided to staff on timely reporting of abuse allegations to the administrator and State agency and on performing a comprehensive investigation. To monitor its performance and to make sure solutions are sustained, random audits on immediate reporting of abuse allegations and the comprehensive investigation will be performed by the ED / Designee until July 1st with audit results reviewed in QAPI quarterly as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11	F 225		

When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by 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 in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON also stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family had first been made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12	F 225		

for R2 and being persistent with the pharmacy.

When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms.

During review of R2's medical record it was verified a fax had been sent to the clinic on 2/16/16 to inform the physician of the allergy. However, the fax was sent to the clinic after hours when the clinic was not open thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes.

When interviewed on 3/8/16, at 2:23 p.m. the DON stated this issue had not been reported to the State agency and/or the administrator in accordance with the facility policy.

During interview with licensed practical nurse (LPN)-A on 3/8/16, at 3:19 p.m., LPN-A stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13 she sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A stated she did not consider sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day. 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.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse/Neglect	F 226	F226 Golden LivingCenter Slayton realizes the	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14 policy to ensure immediate reporting of allegations of potential neglect of treatment to the State Agency (SA) for 1 of 3 residents (R2) reviewed. Findings include: 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	F 226	importance of immediate reporting of allegations of abuse to the administrator and State agency. The policy and procedure for immediate reporting of abuse allegations has been reviewed for resident #R2. To prevent further incident to other residents, re-education will be provided to staff on timely reporting of abuse allegations to the administrator and State agency and on performing a comprehensive investigation. To monitor its performance and to make sure solutions are sustained, random audits on immediate reporting of abuse allegations and the comprehensive investigation will be performed by the ED / Designee until July 1st with audit results reviewed in QAPI quarterly as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 15	F 226		

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 administered the medication as ordered.

When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by 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 in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON also stated F-A had been at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 16	F 226		

facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family had first been made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy.

When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms.

During review of R2's medical record it was verified a fax had been sent to the clinic on 2/16/16 to inform the physician of the allergy. However, the fax was sent to the clinic after hours when the clinic was not open thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes.

When interviewed on 3/8/16, at 2:23 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17 DON stated this issue had not been reported to the State agency and/or the administrator in accordance with the facility policy. During interview with licensed practical nurse (LPN)-A on 3/8/16, at 3:19 p.m., LPN-A stated she sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A stated she did not consider sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day.	F 226		
F 274 SS=D	. 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 18 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document the failed to conduct a comprehensive assessment of a stage II pressure ulcer located on the coccyx for 1 of 4 residents (R5) reviewed for pressure ulcers. Findings include: R5 was admitted on 12/11/15, following a 9 day hospitalization for recurrent pleural effusion on right side (fluid accumulation in the lung). R5 has other diagnoses which include diabetes mellitus II (DM II), osteoarthritis, myocardial infarction (heart attack) and heart failure. R5 requires blood sugar checks and insulin based on a sliding scale, with blood sugars that range between 57-549 with frequent insulin adjustments made by the physician. R5 experienced a fall at the facility on 2/7/16 and sustained multiple left pelvic fractures and a left fracture to elbow and was subsequently hospitalized. R5 was re-admitted to the facility on 2/11/16. According to the review of the weekly skin assessments, R5 had a an open area identified on the buttocks dated 2/2/16. According to the physician note dated 2/5/16, he ordered a foam Tagaderm application to the "sacral wound" every 3 days. There were no measurements nor	F 274	F274 Golden LivingCenter Slayton realizes the importance of updating care plans to reflect our resident's treatments and cares. #R5's care plan has been reviewed and revised as related to pressure ulcer / skin integrity and is receiving care per care plan. R5's Comprehensive Assessment has been updated to reflect the resident's current 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 update the care plan with this information. The IDT (Intradisciplinary Team) will review wound flow sheets and would care plans. Education on the UDA Policy is included as a hard copy in the wound packet. Weekly wound audits including weekly UDA Policy and wound flow sheet / significate change education is given to the nurses. Ongoing education will be given.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. When interviewed on 3/10/16, at 10:45 a.m. the director of nursing (DON) confirmed the assessment process had not been implemented per facility protocol. The Weekly Skin Review policy dated 5/1/15 directs skin alteration findings to be identified, use the figures provided, describe type of alteration and location. It further directs a wound evaluation flow was to be initiated/updated.	F 274	Audits will be done randomly bimonthly.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R40) reviewed for dental services. Findings include: On 3/7/16, at 12:09 p.m. R40 was observed to have broken and missing upper and lower teeth. A physician pre-operative note dated 5/11/15, identified: "Teeth and gums however are in grave need of repair. Many other teeth are broken off, again nothing I can see that appears to be of	F 278	F278 Golden LivingCenter Slayton realizes the importance of timely assessments of its residents. Resident #5 has been reassessed. To prevent other residents from incidents, the facility has re-educated and retrained the RNAC on the comprehensive asessments according to the RAI manual. To monitor its performance and to make sure solutions are sustained, random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 21 concern for abscess; however, again many of the teeth are broken off, whether part of this is related to the accident or poor dental hygiene prior, I do not have data regarding same". A nursing noted dated 12/15/15, identified R40 had own teeth with several missing (no partial for missing dentition); some remaining teeth broken and carious (poor dentition chronic); and resident stated she was not interested in a dental consult. During document review it was noted the significant change MDS dated 12/15/15, did not identify any dental problems. It documented "no problems" even though R40 had many broken/missing teeth. During interview with the MDS coordinator on 3/8/16, at 2:04 p.m. it was verified the significant change MDS dated 12/15/15, did not identify the broken, carious teeth and stated this should have been identified on the MDS.	F 278	audits will be performed bimonthly by the ED / Designee until July 1st with audit results reviewed in QAPI quarterly and as needed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review the facility failed to revise the plan of care for 1 of 4 residents (R5) who was reviewed for pressure ulcers. Findings include: During observations of positioning on 3/8/16, at 1:54 p.m. R5 was observed lying on her right side with her right ear resting on the bed pillow. During a observation on 3/9/16, at 7:12 p.m. R5 was observed to be sleeping in her recliner with both her feet resting on the foot rest; without heel protector on nor feet elevated on a pillow. During a observation on 3/9/16, at 1:07 p.m. it was observed R5's outer right ear had a bloody scabbed area. At that time, R5 indicated she noted a sore on her right ear prior to admission on 12/11/15. R5 further revealed she obtained the sore by laying on her oxygen tubing. Review of the weekly skin review dated 3/1/16, indicated R5 was identified with a reddened right ear (no measurements). Review of the wound evaluation dated 3/3/16, identified right ear measurements to be 0.5 cm length and 1.0 cm width with an intervention that included a neck	F 280	F280 Resident #5 care plans have been reviewed and revised as indicated related to risk for pressure ulcer / skin integrity and is receiving care per care plan. Residents, identified with pressure ulcers, care plans and CNA sheets have been reviewed and revised as indicated and are receiving cares per care plan. Nursing staff and CNAs will be educated to provide cares in compliance with identified interventions in the resident care plan. Random bimonthly audits will be conducted by DNS / Designee to ensure appropriate cares have been completed in conjunction with identified care plan interventions. Audits will be presented at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 pillow. Review of the weekly skin review dated 2/23/16, R5 was identified with a pressure ulcer to the right heel. Review of the wound evaluation dated 3/3/16, identified the left heel measurement to be 2.0 cm length by 2.5 cm width with an intervention that included a heel protector to the left heel. 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 During an interview on 3/09/2016, at 7:04 p.m. director of nursing (DON) verified the care plan had not been revised to include interventions related to R5's pressure ulcers to the right ear and left heel; which included a neck pillow to the right ear and heel protector to the left heel.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 24 by: Based on observation, interview and document review the facility failed to follow the plan of care for 2 of 4 residents (R2, R5) reviewed who were identified at risk for pressure ulcer development and had facility acquired pressure ulcers and for 1 of 3 residents (R1) reviewed who required assistance with grooming. Findings include: R43 was admitted on 12/28/15 with diagnoses listed on his active care plan that included: anemia, depression, anxiety, vertebral fractures, repeated falls and heart failure. On 2/15/16 family elected hospice services related to diagnosis end stage liver cirrhosis. When interviewed on 3/7/16, at 10:39 a.m. the registered nurse (RN) case manager stated R43 had a Stage III pressure ulcer on the sacral region which had developed while R43 was a resident at the facility. R43's care plan dated 3/9/16, identified: skin concern with potential for alteration in skin integrity related to weakness, cognitive communication deficit, urinary dribbling/incontinence, bowel incontinence, cirrhosis of the liver, edema, anemia, decreased appetite/intakes, history moisture associated skin breakdown, history of pressure ulcers, and admitted with a stage I coccyx decub. Interventions included on the care plan included: 1.) Air overlay mattress on bed- pressure relieving cushion in geri-chair; 2.) Braden scale quarterly; 3.) Daily decub monitoring; 4.) Encourage food & fluid intakes;	F 282	F282 Resident #43 and #1 care plans have been reviewed and revised as indicated related to wound staging and diabetic nail cares. Wound flow sheets have been reviewed and updated. Golden LivingCenter Slayton will provide wound education to all licensed staff to complete accurate skin assessments based on evaluation. Golden LivingCenter Slayton's standard is to provide necessary services to maintain grooming and personal hygiene. All diabetic nail care will be completed as assigned on the eTAR by licensed staff. CNA staff will be educated on the ability to clean and file diabetic residents nails as well as general nail care on all residents. Nail audits will be completed randomly and brought to QAPI. Residents identifed with pressure ulcers - the care plans and CNA sheets have been reviewed and revised as indicated and are receiving care per care plan. Nursing staff and CNAs will be educated to provide cares in compliance with identified interventions in the resident care plan. Random bi-monthly audits will be conduted on resident(s) to ensure appropriate cares have been completed in conjunction with the identified care plan interventions and weekly assessments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 25 5.) Encourage to be up & as active as possible; 6.) Monitor and report signs of skin breakdown; 7.) Provide pericare after incontinent episodes; 8.) Skin assessment weekly; 9.) Tissue tolerance testing; 10.) Treatment to altered skin site per M.D. order; 11.) Turn/reposition and/or off-load every hour; 12.) Weekly decubitus update; During observation on 3/9/16, at 10:38 a.m. nursing assistants (NA)- B and NA-C entered R43's room to reposition and provide incontinence care for R43. R43 was rolled onto his left side by NA-B and was noted to have a 4 x 4 foam cover located over his sacral area, and (2) 2 x 4 non-stick dressings above the sacral area. NA-B and NA-C stated R43 had open areas under each dressing and stated they were not aware of the characteristics of the wounds as they were usually positioning R43 onto his side while the nurse was providing treatment to the wounds. NA-B indicated R43 was repositioned hourly with his declining condition and a hospice aide usually came in to feed R43 lunch so they would get him up into recliner prior to lunch. R43 noted to have an air bed and bilateral heel protectors on. During observation of wound cares on 3/9/16, at 11:59 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-B performed wound cares. R43 was noted to have a large foam dressing over his coccyx region and two 4 x 4 dressings above the foam dressing on his sacrum region. The 4 x 4 dressing directly above the foam dressing was noted to have drainage. R43 was also noted to have a quarter sized Stage II PU on his coccyx, a Stage III PU of golf ball size circumference, a wound on his lower sacrum and	F 282	completed. Audits will be presented at QAPI. DNS / Designee is the reponsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 26 a dime sized Stage II pressure above the sacral ulcer. RN-A cleansed each wound with wound cleanser and re-applied dressings to the wounds. 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. 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. 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	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 27	F 282		

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 skin intact.
4. 2/4/16 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 decub monitoring, or monitoring and reporting signs of skin breakdown as directed by the care plan.

On 3/9/16, at 3:20 p.m. the facility nurse consultant was interviewed and verified there were concerns about license staff's ability to measure and assess pressure ulcers and stated staff needed more training.

On 3/9/16, at 4:10 p.m. registered nurse (RN)-C was interviewed and verified during morning dressing change she observed a pressure ulcer on R43's buttocks, in his buttocks crease, approximately quarter sized, a golf ball sized open area on sacral region and a popped blister looking area, dime sized, on her supra sacral region.

On 3/10/16, at 6:58 a.m. licensed practical nurse (LPN)-B was interviewed and stated she worked with R43 either on 3/2/16 or 3/3/16, but remembers R43 had 3 open areas. LPN-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 28	F 282		

identified R43 had a wound on his coccyx, a larger sacral wound, and 1 a smaller wound above the sacral area which would correlate with what was visualized during dressing change observation on 3/9/16.

On 3/10/16, at 8:33 a.m. nursing assistant (NA)-F was interviewed and stated she had worked as a NA with R43 the previous week and R43 had a foam dressing and two additional dressings on his back above the foam dressing.

On 3/10/16, at 9:18 a.m. the DON entered R43's room and measured R43 wounds. R43 was identified with the following open areas.
Coccyx wound in buttocks crease measured 2 cm x 1.8 cm. Sacral wound measured 2.5 cm x 2 cm. Another sacral wound on the periphery of the larger sacral wound measured 0.8 cm x 0.6 cm. The wound above the larger sacral wound measured 1 cm x 1 cm. The DNS stated she was not aware of the supra sacral or peripheral sacral wounds. The peripheral sacral wound had not been noted in any documentation.
Throughout review of R43's medical record it was noted there was not consistent tracking, accuracy of reporting or ongoing monitoring of pressure ulcers even when R43 was identified at high risk related to his long history of pressure ulcer development. The medical record failed to accurately identify wounds or show continuous monitor to reduce R43's risk of further development or deterioration of current pressure ulcers.
On 3/7/16, at 11:11 a.m., and 3/8/16, at 2:09 p.m. R1 was observed in his room with long, jagged fingernails with dark brown debris noted underneath the fingernails on both hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 29	F 282		

On 3/09/16, at 4:16 p.m. R1 was observed lying in bed while in his room and continued to have long, jagged fingernails with brown residue present under the nails. R1 confirmed his fingernails were long and soiled and stated the facility had a class approximately once a week where they soak the nails to clean them and will also file/trim and put polish on the nails. When asked whether staff offer to clean his fingernails in between and he responded, "no." When asked whether he would allow staff to clean and trim his fingernails, R 1 responded affirmatively.

Review of R1's eTAR (electronic treatment administration record) dated March 2016 included: "clean, trim and file finger and toe nails the 15th & 30th of every month. [sic] in the morning every 14 day(s)." The care plan dated 3/1/16, identified an alteration in self care with interventions including: "assist with nail care".

When interviewed on 3/10/16, at 10:50 a.m. nursing assistant (NA)-A stated the nurses were responsible for trimming R1's nails as he is diabetic. NA-A confirmed the NA's assist with cleaning R1's nails in between and that R1 was cooperative with assistance with ADL's.

When interviewed on 3/10/16, at 1:30 p.m. the director of nursing (DON) confirmed NA's were responsible for resident nail care and that the licensed nurses were responsible for trimming R1's nails. The DON verified the NA's should still be cleaning R1's nails and also could file R1's nails as necessary. DON observed R1's fingernails with surveyor and confirmed they were long and soiled. DON stated she would have expected R1's nails to be trimmed by nursing staff per the eTAR (trim on 15th and 30th of each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 30	F 282		

month) and would have expected NA's to clean and file R1's nails as needed per the plan of care. R5 was admitted on 12/11/15, following a 9 day hospital stay for recurrent pleural effusion on right side (fluid accumulation in the lung). R5 has other diagnoses that include diabetes mellitus II (DM II), osteoarthritis, myocardial infarction (heart attack) and heart failure.

R5's care plan initiated on 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.

During an observation on 3/9/16, at 4:53 p.m. licensed practical nurse (LPN)-B measured and applied treatment to the left buttock pressure ulcer. The ulcer was observed to be 2.6 centimeters (cm) by 2.0 cm with a depth of 0.3 millimeters. The pressure ulcer was identified to have rolled edges and a gray wound bed with a large area of redness surrounding it.

During an interview 3/9/16, at 1:00 p.m. R5 reported that she got the sore on her bottom long before she fell [2/7/16]. R5 stated that when staff assisted with personal care she informed them it was sore; they told her she had an open area. R5 stated, "They would put some cream on it and that's all they did. Now its covered. It's still pretty sore and tender. It hurts to sit on it too long so that is why they lay me down often".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 31	F 282		

Documentation revealed the weekly skin assessments did not include wound measurements to monitor progress/decline as part of the weekly skin assessments as identified in the care plan. Documentation in the nursing progress notes dated 1/22/16, identified R5 as having a dark reddened blistered area on left side of buttocks which measured 4.0 cm by 2.0 cm, the area was tender to touch and had previously been treated with barrier cream. Progress notes dated 1/26/16, indicated blistered area on left side of buttocks appeared to have popped and oozed serosanguineous drainage (watery bloody drainage), but no measurement taken. Further review of the nurse progress note for 2/27/16 indicated a dressing was changed on coccyx and identified the ulcer increased in size and was odorous; no measurement. The documentation also noted the wound had yellow edges with a dark center. R5 indicated it hurt more lately.

Review of the weekly skin review dated 2/2/16, indicated an open area on buttocks, healing slowly but not measured. The weekly skin review dated 2/23/16, indicated areas on buttocks currently covered with patches with no measurements. The weekly skin review dated 3/1/16, indicated R5 had open areas to coccyx (no measurements taken). The weekly skin assessment dated 3/8/16, indicated open areas on buttocks only, not measured.

Although, the plan of care included weekly skin assessments and an interventions which included skin monitoring, this had not been implemented for R5's left buttock PU (identified on 1/22/16) as the wound had not been measured consistently to indicate whether healing occurred . In addition, since the weekly skin assessments lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 32 consistent monitoring and measurement of the wound, it was difficult to determine the status of the PU. When interviewed on 3/10/16, at 8:15 a.m. the director of nursing (DON) verified the pressure ulcer on the left buttock should have been appropriately measured and monitored, including measurements so the healing progress could be assessed.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate nursing care and services for 1 of 1 resident (R2) reviewed who had been hospitalized. This resulted in actual harm for R2, who experienced diminished lung sounds, thick yellow sputum and a tight congested cough related to delayed nursing assessment, delayed notification of the family and physician, delayed administration of antibiotic treatment and subsequent transfer to an inpatient facility due to respiratory difficulties. In addition, the facility failed to consistently assess and document monitoring of pain for 1 of 3 residents (R32) reviewed who experienced pain.	F 309	F309 Golden LivingCenter Slayton realizes the improtance to promote care for residents in 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 error discovery and medication was given per order. To prevent further incident, staff have been educated on:	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33 Findings include: When interviewed on 3/7/16, at 2:35 p.m. via telephone, R2's family member (F)-A was questioned about notification by staff when a significant change in the resident's physical health or status occurred. 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 administered the medication as ordered. When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by indicating the medication was	F 309	-Golden LivingCenter Slayton's policy and procedure for contacting families and physician with changes in condition or cares. -On-call physician lists have been obtained by collaborating with clinic manager. -Licensed staff is educated on utilizing on-call physician services. -On admission of residents, it is policy to attempt to identify reactions to medications listed as allergies. -Licensed nurses will be educated on a system to ensure proper assessment of residents -Random bi-monthly audits will be obtained and brought to QAPI. Education and immediate intervention took place at the time of the medication error. The medication error was reported to the DNS by Resident #2's family member. It is the policy of Golden LivingCenter Slayton to administer medications in a timely manner. If medication is deemed possibly not obtainable within a timely manner, the resident's physician will be notified during clinic hours and the on-call physician will be notifed after hours so as to obtain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 34 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]. There was no further documentation in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family was first made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy. When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the	F 309	Random bimonthly audits of new orders will be completed and the DNS or designee will review. Continued education will be provided as needed. Resident #32 pain has been reassessed to prevent further occurance. Licensed staff will be educated on pain control and proper pain medication administration and followup for effectiveness. Random bimonthly audits of pain medication administration will be obtained. Random bimonthly audits for change of condition will be obtained. Audits will be brought to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 35	F 309		

antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms.

The following progress notes were recorded in R2's medical record:

On 2/12/16 at 12:00 p.m., "...This nurse went into room and noted resident lying in bed audible wheeze heard. 2+ edema noted to bilateral feet. Resident has frequent non productive cough when lying down. Resident has had frequent episodes with edema to bilateral feet...VS (vital signs) obtained and lung sounds listened to per stethoscope and noise noted in right lobes where left lobes sounded diminished. Resident denies feeling ill. Fax sent to MD (medical doctor) and daughter to be notified when she comes in facility."

On 2/13/16 at 5:29 p.m., family approached this nurse tor report [R2] was not waking up today and not transferring well. The note indicated the family had also reported R2 had a frequent cough. The documented note included, "Residents condition has changed this week. She has been more difficult to transfer and has had more edema to feet and more cough... Lung sounds diminished in right and sounds noted in left. Frequent cough noted. Call placed to Dr. (doctor) on call at hospital and order received for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 36	F 309		

Duoneb's q (every) 4 hours prn (as needed) and for Prednisone 60 mg (milligrams) po (orally) today and tomorrow and to check with Dr... on Monday..."

An undated note documented on the back side of the progress notes included, "On 2/16, resident returned from seeing Dr ...at clinic. New orders were for Azithromycin 500 mg first dose then 250 mg daily x 4 days. Order was sent to (name of pharmacy). They returned the order stating residnet had an allergy to this medicine & double check with Doctor. Resent to Dr...& returned stating start & monitro for reaction. This was again faxed to (name of pharmacy). On Thursday morning (name of pharmacy) calls to see what was happening with order. I stated that I sent it last night, where upon she asked me to fax it again, with the promise that it would be sent out on that evening run. Order was left on med cart to be put in MAR (medication administration record) once the medicine arrived. The EDU E-kit (emergency medication kit) was checked for a supply of this med, & had only had one pill of 250 mg in stock."

On 2/17/16 at 5:37 a.m., "Resident removed C-Pap per self throughout night. Oxygen saturation @ (at) 4:30 a.m. was 70% RA (room air). Applied PRN oxygen via nasal cannula @ 4 L.(liters) Neb (nebulizer) treatment completed. Oxygen increased to 96%. Oxygen saturation at this time 98% with 4 L oxygen."

On 2/17/16, at 4:03 p.m. "Fax returned from Dr...to start Azithromycin as ordered & monitor for allergy. (Name of pharmacy) notified.

On 2/19/16, at 10:11 a.m, "Res (resident) ill today

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 37	F 309		

wt (weight) not done." A subsequent notation at 11:39 a.m. included, "resident's family member in to visit today, has concerns regarding resident medications. Discovered antibiotic had not been started r/t allergy concern. Upon visiting with daughter discovered allergy to erithromycin is an intolerance not a true allergy. Zithromycin started this am (morning) and prednisone started on 2/18/16. Pt has a hoarse voice, congested tight cough, very dm (diminished) lung sounds from mid lobe down no real air flow heard. Upper lobes clear. Resident sats 90-91% with 2 liters of oxygen. Resident frequently removes oxygen and sat drops to 87-88%. does not appear to have dyspnea and denies shortness of breath (sob). Appears ill looking. Temp 99.9... Fax sent to Dr...with above info (information) and daughter notified."

On 2/19/16, at 11:51 a.m. "called and spoke with daughter about fax to doctor, discussed lung sounds, low grade temp and resident not leaving oxygen on. Discussed she is not sob (short of breath) at this time. Daughter asked if she may have pneumonia discussed it is possible but would need to see a doctor to determine this. She wants to just see how it goes for now. Discussed resident can be seen at clinic if she changes her mind. Call placed to (pharmacy name) to inform of allergy.

On 2/19/16, at 2:24 p.m. the notes included, "1330 (1:30 p.m.) MD returned faxed with orders to admit to hospital. Daughter...notified et (and) in agreement- Fax sent to transfer per ambulance. Ambulance notified...Daughter here et resident transferred at 1400 (2 p.m.)..."

During interview on 3/08/16, at 3:19 p.m. licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 38 practical nurse (LPN)-A stated she had received the message from the pharmacy regarding R2's allergy to Azithromycin and had sent a fax to the physician related to the concern about the allergy. During review of R2's medical record it was verified LPN-A had sent a fax to the clinic on 2/16/16 to inform the physician of the resident's allergy. However, the fax had been sent to the clinic after hours while the clinic was not open, thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes. LPN-A stated she'd sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A further clarified she had not considered sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day. When interviewed on 3/8/16, at 1:47 p.m. the pharmacy consultant stated the facility should have contacted the physician to identify whether a different medication would be appropriate as the pharmacy would not typically contact the physician. The pharmacy consultant stated the facility could have questioned the use of an alternative medication and should have had the physician send the pharmacy an order to indicate he wanted to go ahead and use the Azithromycin, and the pharmacy would have filled the prescription. When interviewed on 3/8/16, at 3:25 p.m. the DON and the administrator verified there should have been more timely follow up regarding the antibiotic prescribed by the physician.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 39	F 309		

When interviewed on 3/10/16, at 9:00 a.m. F-A stated LPN-B had informed F-A on the morning of 2/19/16 while she was visiting R2, that R2 had not received the medication (Azithromycin) as prescribed by the physician. F-A stated if she (F-A) hadn't brought the concern to the DON's attention she was not sure it would have been taken care of. F-A reiterated that if R2 had received the medication as ordered, she (F-A) felt the hospitalization could potentially had been prevented.

When interviewed on 3/10/16, at 12:35 p.m. LPN-B stated she recalled having asked F-A about the Azithromycin allergy for R2 on Saturday morning [2/13/16] and F-A identified there was not an allergy but an intolerance instead.

The facility failed to promptly contact R2's physician to inform him of the identified allergy alert to the prescribed Azithromycin. When the pharmacy declined to fill the prescription without the physician's approval, in lieu of contacting the on-call physician, staff sent a fax to the resident's physician. The clinic was closed for the day when the fax was sent, therefore intiation of an antibiotic to treat R2's URI was delayed. When staff finally received notice from R2's physician that the Azithromycin should be administered, the medication was still not administered for an additional two days. R2 was hospitalized due to a declining respiratory status, URI, for which the antibiotic had been originally ordered.

It was observed on 3/7/16, at 11:33 a.m. that R32 moved her head and neck very slowly, appearing to be in pain. When interviewed at this time R32 reported experiencing pain in back, neck, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 40	F 309		

shoulders. R32 stated that she received a scheduled pain medication earlier that morning which helped with the pain. R32 then rated the current pain level "8" on a scale of 1-10.

R32's quarterly Minimum Data Set (MDS) assessment dated 2/26/16, indicated intact cognition, extensive assistance with bed mobility, transfer, walk in room/corridor, locomotion on unit, dressing, and personal hygiene. The assessment further indicated R32 experienced frequent pain and was on a scheduled pain medication regimen.

R32's care plan dated 2/29/16, indicated a potential for pain and discomfort related to (r/t) diagnosis (dx) of generalized pain, kyphosis (abnormally excessive rounding of the back), cervicalgia (neck pain), history of (h/o) chronic migraines, h/o chronic complaints of (c/o) right (R) arm/shoulder/neck pain, h/o abdominal pain and pain below bilateral knees. Interventions included pain assessment quarterly and prn (as needed), and to monitor and report signs of pain/discomfort.

The signed physician orders dated 2/22/16, included: Tramadol HCl 50 milligrams (mg) three times a day for pain; acetaminophen [Tylenol] 325 mg every 6 hours prn for pain rating 1-5 out of 10; and acetaminophen 650 mg every 6 hours prn for pain rated 5-9 out of 10.

The physician progress note dated 2/22/16 included: "At present, she still complains of a lot of pain in that right arm, which may be related to the old CVA (cerebrovascular accident/stroke) or may be related to the arthritic changes that have occurred in that right shoulder and arm. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 41	F 309		

present, we will continue to keep an eye on this and see how she does with it; indicates that it is controlled at present."

On 3/09/16, at 2:19 p.m. R32 was seated in wheelchair in her room with a tray table in front of her listening to the television. When interviewed at that time, R32 stated her right arm was hurting and felt "out of place"; R32 expressed a pain rating of "8" out of 10. R32 then activated her call light to request to speak to the nurse. Nursing assistant (NA)-B entered the room a short time later and R32 requested to speak to licensed practical nurse (LPN)-B about the pain she was experiencing in her right arm; NA-B exited R32's room to alert the nurse.

On 3/9/16, at 2:30 p.m. when registered nurse (RN)-C entered R32's room, R32 stated her (R) arm was hurting and it felt "out of place". R32 further explained this had happened in the past and the therapist had put it back into place. RN-C asked R32 if she would like the therapist to come and assess. R32 refused and requested that LPN-B be summoned as she knew more about it; R32 then started to cry. RN-C asked R32 if she was in pain and R32 replied she was always in pain but that sometimes her arm would go out. R32 was observed with (R) arm bent at the elbow; R32 exhibited not being able to extend and straighten her (R) forearm forward. RN-C comforted the resident and stated she would have LPN-B talk with her per the resident's request.

On 3/9/16, at 2:36 p.m. LPN-B entered R32's room and questioned the resident pertaining to the (R) arm pain. R32 stated her upper arm was hurting and that she couldn't extend it out straight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 42	F 309		

R32 then exhibited how far she could stretch her (R) arm; the arm remained bent at the elbow and she was able to partially extend the forearm. R32 stated this had only happened once prior and the therapist had done something to put it back into place. LPN-B indicated being unaware R32 had that problem in the past and explained that 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 43	F 309		

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 the stated ineffectiveness of the prn.

Further review of the eMAR dated 3/9/16, indicated R32's scheduled Tramadol 50 mg three times a day did not include a pain rating for the 4:00 p.m. dose. The pain rating for the 8:00 p.m. scheduled Tramadol dose indicated a pain rating of 9 out of 10 at the time of administration.

When interviewed on 3/9/16, at 6:30 p.m. the director of nursing (DON) confirmed that administration/charting of prn medication is directly linked from the eMAR to the electronic progress notes and should include a 1-10 rating of the resident's pain. The DON further stated she would expect charting to include the location of the resident's pain.

On 3/10/16, at 11:18 a.m. R32 was observed lying in bed resting. When questioned whether she was experiencing any pain. R32 denied stating, "No, because I had a pain pill." R32 further stated having pain in her (R) arm earlier when in the dining room and when reported to staff, the nurse administered a pain pill. R32 stated she continued to have the same problem as yesterday, stating her (R) arm wouldn't release at the elbow and that her (R) hand and fingers felt numb. R32 indicated that no nurse had inquired about her (R) arm today when she was administered the scheduled pain medication. Review of the eMAR dated 3/10/16, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 44	F 309		

R32 was given scheduled Tramadol 50 mg at 8:00 a.m. with a pain rating of 8 out of 10 at time of administration.

When interviewed on 3/10/16, at 11:58 a.m. RN-B confirmed giving R32 the scheduled 8:00 a.m. Tramadol, and further confirmed the resident had c/o back and (R) arm pain rated 8 out of 10 at that time. RN-B stated the resident usually always reported some pain when given the scheduled Tramadol but usually rated 4-5 out of 10. RN-B stated the rating of 8 this morning and 9 last night were not typical (higher) for R32. RN-B stated R32 also had prn Tylenol available to use between scheduled doses of Tramadol for breakthrough pain. RN-B stated when administering prn medications, she would document a chart note related to the pain, but only rated the pain when administering the scheduled pain medication (Tramadol). RN-B confirmed she would not necessarily document a progress note r/t pain for the scheduled medication.

When interviewed on 3/10/16, at 12:10 p.m. LPN-B confirmed she had not documented a progress note pertaining to R32's (R) arm pain on 3/9/16 and should have done so. LPN-B further confirmed the pain R32 described in the (R) arm to her knowledge was unusual as no other staff could recall the resident c/o this sort of pain in the past. LPN-B again confirmed R32's c/o (R) arm pain should have been documented even though she had communicated the information during report.

When interviewed on 3/10/16, at 1:20 p.m. the DON confirmed she would expect prn medications to include a progress note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 45 documented by the nurse indicating the reason the medication was given, an assessment/location of the pain, pain scale rating, and follow up r/t to effectiveness. The Pain Management Guideline effective 2/10/15, under GUIDELINE included: "Assessing pain and evaluating response to pain management interventions using a pain management scale based on patient/resident self-report or objective assessment for the cognitively impaired. Documenting pain assessment and interventions prior to giving medication. Evaluation activities should be recorded in a concise manner per the plan of care. Nursing staff should utilize the electronic pain evaluation and nursing note link when it is available." Under MONITORING/COMPLIANCE included: "Documentation and observation of care and treatment reflects ongoing monitoring of pain levels and interventions (pharmacological and non-pharmacological). The documentation will be reflected on the eMAR and progress notes."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide nail care for 1	F 312	R312 Golden LivingCenter Slayton's standard is	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 46 of 3 residents (R1) reviewed for activities of daily living (ADLs). Findings include: On 3/7/16, at 11:11 a.m., and 3/8/16, at 2:09 p.m. R1 was observed in his room with long, jagged fingernails with dark brown debris noted underneath the fingernails on both hands. On 3/09/16, at 4:16 p.m. R1 was observed lying in bed while in his room and continued to have long, jagged fingernails with brown residue present under the nails. R1 confirmed his fingernails were long and soiled and stated the facility had a class approximately once a week where they soak the nails to clean them and will also file/trim and put polish on the nails. When asked whether staff offer to clean his fingernails in between and he responded, "no." When asked whether he would allow staff to clean and trim his fingernails, R 1 responded affirmatively. R1's quarterly minimum data set (MDS) assessment dated 2/26/16, included a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating intact cognition. The MDS also identified that R1 required extensive assistance with personal hygiene. The care plan dated 3/1/16, identified an alteration in self care with interventions including: "assist with nail care". Review of R1's eTAR (electronic treatment administration record) dated March 2016 included: "clean, trim and file finger and toe nails the 15th & 30th of every month. [sic] in the morning every 14 day(s)."	F 312	to provide necessary services to maintain grooming and personal hygeine. Resident #1 nail care was provided at the time of finding. All diabetic nail care will be completed as assigned on the eTAR by licensed staff. CNA staff will be educated on the ability to clean and file diabetic resident nails as well as general nail care on all residents. Nail audits will be comleted randomly and brought to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 47 When interviewed on 3/10/16, at 10:50 a.m. nursing assistant (NA)-A stated the nurses were responsible for trimming R1's nails as he is diabetic. NA-A confirmed the NA's assist with cleaning R1's nails in between and that R1 was cooperative with assistance with ADL's. When interviewed on 3/10/16, at 1:30 p.m. the director of nursing (DON) confirmed NA's were responsible for resident nail care and that the licensed nurses were responsible for trimming R1's nails. The DON verified the NA's should still be cleaning R1's nails and also could file R1's nails as necessary. DON observed R1's fingernails with surveyor and confirmed they were long and soiled. DON stated she would have expected R1's nails to be trimmed by nursing staff per the eTAR (trim on 15th and 30th of each month) and would have expected NA's to clean and file R1's nails as needed per the plan of care.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary	F 314	F314 R43 and R5 wound care has been	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 48 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 indicated the family had elected to utilize hospice services 2/15/16 related to diagnosis end stage liver cirrhosis. During interview with the registered nurse (RN)-A on 3/7/16 at 10:39 a.m., RN-A stated R43 had a Stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss) which had developed to the sacral region while R43 was a resident at the facility. The admission Minimum Data Set (MDS) assessment dated 1/2/16, identified R43 with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also identified R43 required extensive assist with bed mobility and dressing, was dependent of staff for transfers and did not ambulate. The MDS further identified R43 with frequent bowel and bladder incontinence and a Stage I pressure ulcer (a defined area of persistent redness in lightly	F 314	reviewed and weekly wound audits have been updated. Residents identified as at risk for the development for pressure ulcers or current ulcers has the potential to be affected. Nursing staff will be educated to provide cares and services identified in the care plan that promote healing of pressure ulcers. Licensed staff have been educated to documetation of wound care weekly with recommended interventions and cares. Random bimonthly audits will be conducted until July 1st on residents with identified pressure ulcers to ensure cares and services offered promotes cares and healing of said ulcer, identify care plan interventions, and documentation of wound care and changes. Audits will be presented at QAPI for reivew.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 49 pigmented skin). Progress notes documented in R43's medical record identified the following: -12/31/15 Resident has redness on buttocks. Small (1 centimeter (cm) x 1.5 cm) opening on coccyx; foam dressing in place. Superficial at this time. Will continue to monitor. -12/31/15, at 1:51 p.m. Resident is incontinent of bowel & bladder. He is checked and changed routinely. Has no scheduled treatments but coccyx has red area noted, Mepilix (an absorbent, atraumatic dressing made from polyurethane foam) applied for preventive measures. No restraints used as resident is unable to move per self. Needs extensive assist with all ADL's (activities of daily living) - unable to do anything per self at this time. -1/1/16, at 2:23 p.m. called to room by NAs (nursing assistants) - resident's coccyx has two open areas noted which started as blisters that have broken open, tegaderm foam adhesive dressing applied, staff will reposition resident to keep off area when in bed. Will fax doctor tomorrow as today 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 received with order to place a tegaderm to open areas on coccyx. -1/11/16, at 2:49 p.m. dressing changed on coccyx area, no improvement noted in area.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 50 Continues to need extensive assist with repositioning, dressing, grooming, set up & eating meals, -1/14/16, at 10:30 a.m. has history of a pressure ulcer on his right (R) elbow during prior facility admission, that has healed. Current interventions include an air overlay mattress on his bed, a pressure relieving cushion on his geri-chair, a check and change program for optimal dryness and cleanliness, scheduled turning/repositioning every (q) 2 hours, and use of air filled pressure relieving boots to both legs/feet. -1/16/16, at 12:46 p.m. Requires assist of 2 staff members with cares and with repositioning due to pain issues. Tegaderm in place to coccyx and staff changes that q day. Requires total assist with feeding and with cares. Is repositioned q 2 hours due to pressure area. -1/24/16, at 10:39 p.m. Total dependence with all ADLs. Difficult to dress related to shoulder. Incontinent of bowel and bladder. Area on coccyx is draining serosanguineous drainage. Buttocks remain red. -1/25/16 1:55 p.m. Receives PT/OT/ST (physical therapy, occupational therapy, speech therapy) 5 x/week for strengthening. Coccyx area is very excoriated and tender, Carona (non-stick gel dressing) applied. 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.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 51	F 314		

Receives supplements bid (twice daily). Pt has denied pain today.

The 3/9/16 care plan for R43 identified: skin concern with potential for alteration in skin integrity related to weakness, cognitive communication deficit, urinary dribbling/incontinence, bowel incontinence, cirrhosis of the liver, edema, anemia, decreased appetite/intakes, history moisture associated skin breakdown, history of pressure ulcers, admitted with a stage I coccyx decubitus. Care Plan interventions included: (1.) Air overlay mattress on bed, (2) pressure relieving cushion in geri-chair, (3) Braden scale quarterly, (4) Daily decub (decubitus ulcer) monitoring, (5) Encourage food & fluid intakes, (6) Encourage to be up & as active as possible, (7) Monitor and report signs of skin breakdown, (8) Provide pericare after incontinent episodes, (9) Skin assessment weekly, (10) Tissue tolerance testing (assessment of the tolerance of the resident's tissue to prolonged pressure), (11) Treatment to altered skin site per M.D. (medical doctor) order, (12) Turn/reposition and/or off-load every hour, and (13) Weekly decubitus update

During observation on 3/9/16, at 10:38 a.m. NA-B and NA-C entered R43's room to reposition and provide incontinence care for R43. R43 was rolled onto his left side by NA-B and was noted to have a 4 x 4 foam dressing located over his sacral area, and two 2 x 4 non-stick dressings above the sacral area. NA-B and NA-C stated R43 had open areas under each dressing and stated they were not aware of the characteristics of the wounds as they were usually positioning R43 onto his side while the nurse was providing treatment to the wounds. NA-B stated R43 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 52	F 314		

repositioned hourly due to his declining condition. NA-B also stated a hospice aide usually came in to feed R43 lunch so they would get R43 up into his recliner prior to lunch. During this observation, R43 was noted to have an air bed and bilateral heel protectors on.

R43's current physician orders identified treatments that included:
1. Calcium alginate with silver wound dressing following wound cleanser then cover with Allevyn and tegaderm every 5 days and PRN;
2. Foam dressing to area on right hip where resident is scratching, change as needed;
3. Bilateral air filled pressure relieving boots on at all times, except for bathing;
4. Turn/reposition and/or off-load every one hour.

During observation of wound cares on 3/9/16, at 11:59 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-B performed wound cares. R43 was noted to have a large foam dressing over his coccyx region and two 4 x 4 dressings above the foam dressing on his sacrum region. The 4 x 4 dressing directly above the foam dressing was noted to have drainage. R43 was also noted to have a quarter sized Stage II PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) on his coccyx, a Stage III PU of golf ball size circumference, a wound on his lower sacrum and a dime sized Stage II pressure above the sacral ulcer. RN-A cleansed each wound with wound cleanser and re-applied dressings to the wounds.

R43's Minimum Data Set (MDS) assessments identified R43 with the following pressure ulcers:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 53 -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. The weekly skin assessments documented in the record were incomplete and/or inaccurate as they did not correlate with the MDS assessments and the wound evaluation flowsheet documentation. The following was noted on the weekly skin assessments:. (1.) 1/14/16- identified coccyx- no description of wounds. (2.) 1/21/16- identified open areas on coccyx but no details of characteristics. (3.) 1/28/16 -identified skin intact; (wound flowsheet identiied unstageable and Stage I) (4.) 2/4/16-identified a large open area on coccyx; multiple open areas on bilateral buttocks; and dressings in place. 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. There was a discrepancy between the wound evaluation flowsheets documentation and the nursing progress notes. The documentation revealed inconsistent assessments of the condition of R43's skin. A 3rd PU located on R43's sacrum was identified on 3/9/16, which measured 0.5 cm x 1.0 cm.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 54	F 314		

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.

When interviewed on 9/9/16, at 1:00 p.m. the director of nursing (DON) stated she was unaware that R43 had 3 PU's. The DON stated she realized there was some inconsistency in assessing pressure ulcers due to lack of training of some of the licensed staff.

When interviewed on 3/9/16, at 3:20 p.m. the facility nurse consultant verified there were concerns about license staff's ability to measure and assess pressure ulcers and stated staff needed more training.

On 3/9/16, at 4:10 p.m. RN-C was interviewed and verified during morning dressing change she observed a PU on R43's buttocks, in the buttocks crease, approximately quarter sized, a golf ball sized open area on sacral region and a popped blister looking area, dime sized, above the sacral wound.

On 3/10/16, at 6:58 a.m. LPN-B was interviewed and stated she worked with R43 either on 3/2/16 or 3/3/16, but remembers R43 had 3 open areas. LPN-B identified R43 had a wound on his coccyx, a larger sacral wound, and 1 a smaller wound above the sacral area which was the same area observed during dressing 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 55 additional dressings on his back above the foam dressing. On 3/10/16, at 9:18 a.m. the DON measured R43 wounds and identified the following 4 open areas: #1-coccyx wound in buttocks crease measured 2 cm x 1.8 cm.; #2-sacral wound measured 2.5 cm x 2 cm.; #3-additional sacral wound on the periphery of the larger sacral wound measured 0.8 cm x 0.6 cm.; and #4 wound located above the larger sacral wound measured 1 cm x 1 cm. The DON stated she was not aware of the supra sacral or peripheral sacral wounds. The peripheral sacral wound had not been noted in any documentation found in the medical record. Throughout review of R43's medical record it was noted there was inconsistent tracking, accuracy of reporting or ongoing monitoring of pressure ulcers even when R43 was identified at high risk related to his long history of pressure ulcer development. The medical record failed to accurately identify wounds or show continuous monitor to reduce R43's risk of further development or deterioration of current pressure ulcers. R43 had developed four (4) stage II or greater pressure ulcers since his admission to the facility and continued to show risk for ongoing deterioration and breakdown. The wound on R43's sacrum was evaluated on 1/28/16, as a 1 cm x 1.5 cm wound and not evaluated again until 3/4/16 when it had progressed to a 2.3 cm x 2.1 cm open pressure ulcer. There was evidence R43 sustained harm related to the facility's failure to accurately monitor the progression of wounds and R43 remained at risk for development of further pressure ulcers as noted by the development of the fourth pressure ulcer during the survey. R5 was admitted on 12/11/15, following a 9 day	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 56	F 314		

hospital stay for recurrent pleural effusion on right side (fluid accumulation in the lung). R5 has other diagnoses that include diabetes mellitus II (DM II), osteoarthritis, myocardial infarction (heart attack) and heart failure. R5 requires blood sugar checks and insulin based on a sliding scale. The blood sugars were usually high with some lows ranging from 57-549 with frequent insulin adjustments made by the physician. R5 had a fall at the facility on 2/7/16, sustained multiple left pelvic fractures and a left fracture to elbow and was subsequently hospitalized until 2/11/16 when re-admitted to the facility. The Minimum Data Set (MDS) dated 2/18/16, R5 required extensive assistance with bed mobility and transferring.

During observations of positioning on 3/8/16, at 1:54 p.m. it was noted R5 was lying on her right side with her head and right ear directly on the pillow.

During an observation on 3/9/16, at 1:07 p.m. it was noted that R5's outer right ear had a bloody scabbed area. At that time, R5 indicated she noted the sore area prior to admission in December and explained she received it from laying on her oxygen tubing.

During an observation on 3/9/16, at 4:53 p.m. licensed practical nurse (LPN)-B measured and applied treatment to the left buttock PU. The wound was observed to be 2.6 centimeters (cm) by 2 cm with a depth of 0.3 millimeters, had rolled edges, gray wound bed with a large area of redness surrounding it. The heel ulcer was observed to be a large reddened area that LPN-B reported was soft when pressure applied. LPN-B did not measure the heel wound and verified it was no longer a blistered area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 57 On 3/9/16, at 7:12 p.m. R5 was noted to be sleeping in her recliner 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 open areas or pressure ulcers. Review of the nurse progress notes dated 1/22/16, identified R5 as having a dark reddened blistered area on left side of buttocks which measured 4 cm by 2 cm, was tender to touch and had previously been treated with barrier cream. A notification was sent to the physician on 1/22/16. When reviewing the weekly skin assessments, R5's skin was identified as intact with no areas of redness until the 1/26/16, even though it was identified on the left buttock as noted in the nurse progress notes. In contrast, the nurse progress note dated 1/26/16, indicated that a blistered area on left side of buttocks appeared to have popped and oozed serosanguineous drainage (watery bloody drainage), but no measurement taken. Review of the weekly skin assessment dated 2/2/16, indicated an open area on buttocks, healing slowly but not measured. On 2/5/16, R5's physician made a clinical visit to facility and ordered a foam tegaderm dressing to the sacral wound to be changed every 3 days and as needed. Review of the weekly skin assessment dated 2/23/16, indicated areas on buttocks currently covered with patches and newly identified red area on the left heel, neither were measured.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 58	F 314		

Review of the nurse progress note for 2/27/16, indicated the dressing was changed on coccyx and had increased in size and was odorous. It also noted that wound had yellow edges with a dark center. R5 indicated it hurt more lately.

Review of the weekly skin assessment dated 3/1/16, indicated R5 had an open areas coccyx and right ear (no measurements taken). No further reassessments were available for review in the record nor when requested from staff.

Review of the Wound evaluation form dated 3/3/16, the flowsheet indicated PU's were facility acquired and were located on the left heel, left buttock and right ear. Measurements were noted. A fax was sent to the physician regarding the ulcer on coccyx, the reddened right ear and the blister on back of left heel. Physician orders were received 3/4/16, to treat all 3 areas. Further review of the right ear wound evaluation noted the ear was a Stage II, open, painful and tender to touch.

Review of the weekly skin assessment dated 3/8/16, indicated open area on buttocks only, not 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 59	F 314		

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 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.

Review of the Tissue tolerance observance was completed 12/16/15, and indicated R5's skin was 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 60	F 314		

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 interventions 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 medication record nor had not been initiated. The DON was unaware the ear was open with bloody scabbing. She further verified there were no interventions put into place to relieve pressure from the ear while R5 was lying in bed.

During an interview on 3/8/16, at 1:12 nursing assistant (NA)-C indicated R5 was not on a turning schedule stating "she lets us know. We lay her down and toilet when she asks. We are doing something with her 6 times a day".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 61	F 314		

During an interview 3/9/16, at 1:00 p.m. R5 reported that she got the sore on her bottom long before she fell [2/7/16]. R5 stated that when staff assisted with personal care she informed them it was sore; they told her she had an open area. R5 stated, "They would put some cream on it and that's all they did. Now its covered. It's still pretty sore and tender. It hurts to sit on it too long so that is why they lay me down often".

During an interview on 3/9/16, at 7:04 p.m. DON verified the treatment was not documented on the TAR as ordered by the physician nor were interventions noted on the care plan and aid worksheets.

The identified wound ulcers were documented as follows:
Left buttock measurements (identified 1/22/16):
1/22/16- length 4 cm, width 2 cm, no depth reddened blister area;
2/13/16-length 2.4, width 1 cm;
Undated wound evaluation week 1: 2.4 cm, width 1 cm, no depth, Stage I
3/3/16-Wound evaluation wk 2: length 2 cm, width 2.5 cm, no depth Unstageable

Heel measurements (identified 2/23/16):
3/3/16-length 2 cm, width 2.5 cm.

Ear measurements (identified 3/1/16):
3/3/16-length 0.5 cm, 1 cm width, no depth

Throughout review of R5's medical record it was noted there was not consistent tracking, accuracy of reporting nor ongoing monitoring of PU's even when R5 was identified at high risk for PU development. The medical record documentation did not accurately and consistently identify all of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 62 the wounds nor or did it demonstrate continuous monitoring to reduce R5's risk of further development or deterioration of current pressure ulcers. The Weekly Skin Review policy dated 5/1/15, directs skin alteration findings to be identified, use the figures provided, describe type of alteration and location. It further directs a wound evaluation flow was to be initiated/updated, the MD/NP were to be notified and care plans were to be updated with new interventions. A policy related to pressure ulcer was requested and not submitted. The wound on R5's left coccyx was documented on 1/26/16 as an open blistered area 4 cm by 2 cm and not evaluated again until 3/3/16, when it had progressed to a 2.5 cm x 2 cm open pressure ulcer. There was evidence R5 sustained harm related to the facility's failure to accurately assess and monitor the progression of identified wounds. R5 remained at risk for development of further pressure ulcers as noted by the development of the left heel and right ear pressure ulcer.	F 314		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 63 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly label and store medications to ensure safe administation of medications. This has the potential to affect any of the 38 residents who reside in the facility. Findings include: During the medication pass on 3/9/16, at 4:22 p.m. licensed practical nurse B (LPN-B) was observed preparing medications for R2. R2 was scheduled to receive a Symbicort inhaler. The Symbicort inhaler did not have a medication label	F 431	F431 R2 and R15 medications have been reviewed for proper labeling. Pharmacy will complete cart audits of medication labeling. Licensed staff have been educated on labeling of OTC medication to ensure safe administration of medication. Random bimonthly audits will be completed until July 1st and brought to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 64 on it. LPN-B then retrieved a new inhaler that did have a label on it before administering the medication. During inspection of the north/south cart the following medications were found without labels: Liquitears 1.4% eye drops 3 bottles, Systane eye drops 3 bottles, Timolol eye drops 0.5% 1 bottle, and Lantaprost 0.0005% eye drops 1 bottle. In addition, an open bottle of Oxyfloxin 0.3% eye drops was noted with R15's name written on the bottle. The label on the bottle said E-Kit 1/31/16. The medication was ordered 2/2/16 and discontinued 2/8/16. A medication card of Mucinex 600 mg with 9 pills remaining in the card was evident and no label was on the medication. During interview with LPN B on 3/9/16, at 4:22 p.m. she verified that R2's inhaler should have had a label on it. On 3/10/16, at 10:31 a.m. LPN-B stated she did not know why the Mucinex was stored in the cart and indicated she did not know whether it was a stock medication or an individual prescription for a resident. When interviewed on 3/10/16, at 10:56 a.m. the director of nursing (DON) verified the discontinued Oxyfloxin eye drops for R15 should have had a label and been discarded when discontinued. She also verified that all eye drops should have the appropriate labels with the resident's name. The policy PRODUCT LABELING AND PACKAGE TYPES revised 5/13/15, identified "All medication orders dispensed by the Pharmacy are labeled in accordance with all Federal and State regulations."	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 65 Procedures: A. Medications dispensed to residents are appropriately and safely labeled. The label shall have: 1. Any labeling that is consistent with law, regulation and professional practice 2. Expiration dates of a maximum of one year or the manufacturer's original date, whichever is less 3. Any applicable or cautionary statements	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/10/2016**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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.	K 000		

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

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.

MDH
Minnesota
Department
of Health

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 7th, 8th, 9th and 10th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status 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: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the family and physician in a timely manner for 1 of 1 resident (R2) reviewed for hospitalization who experienced significant changes in her respiratory condition requiring medical treatment. This resulted in actual harm for R2, who experienced diminished lung sounds and a congested tight cough related to delayed physician notification regarding failure to initiate prescribed antibiotic medication to treat an upper respiratory infection, with subsequent transfer to an inpatient facility for respiratory distress. Findings include: When interviewed on 3/7/16, at 2:35 p.m. via telephone, R2's family member (F)-A was questioned about notification by staff when a significant change in the resident's physical health or status occurred. 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	2 265	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4	2 265		

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 administered the medication as ordered.

When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by 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]. There was no further documentation in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5	2 265		

family was first made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy.

When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms.

The following progress notes were recorded in R2's medical record:

On 2/12/16 at 12:00 p.m., "...This nurse went into room and noted resident lying in bed audible wheeze heard. 2+ edema noted to bilateral feet. Resident has frequent non productive cough when lying down. Resident has had frequent episodes with edema to bilateral feet...VS (vital signs) obtained and lung sounds listened to per stethoscope and noise noted in right lobes where left lobes sounded diminished. Resident denies feeling ill. Fax sent to MD (medical doctor) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 daughter to be notified when she comes in facility." On 2/13/16 at 5:29 p.m., family approached this nurse tor report [R2] was not waking up today and not transferring well. The note indicated the family had also reported R2 had a frequent cough. The documented note included, "Residents condition has changed this week. She has been more difficult to transfer and has had more edema to feet and more cough... Lung sounds diminished in right and sounds noted in left. Frequent cough noted. Call placed to Dr. (doctor) on call at hospital and order received for Duoneb's q (every) 4 hours prn (as needed) and for Prednisone 60 mg (milligrams) po (orally) today and tomorrow and to check with Dr... on Monday..." An undated note documented on the back side of the progress notes included, "On 2/16, resident returned from seeing Dr ...at clinic. New orders were for Azithromycin 500 mg first dose then 250 mg daily x 4 days. Order was sent to (name of pharmacy). They returned the order stating residnet had an allergy to this medicine & double check with Doctor. Resent to Dr...& returned stating start & monitro for reaction. This was again faxed to (name of pharmacy). On Thursday morning (name of pharmacy) calls to see what was happening with order. I stated that I sent it last night, where upon she asked me to fax it again, with the promise that it would be sent out on that evening run. Order was left on med cart to be put in MAR (medication administration record) once the medicine arrived. The EDU E-kit (emergency medication kit) was checked for a supply of this med, & had only had one pill of 250 mg in stock."	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7 On 2/17/16 at 5:37 a.m., "Resident removed C-Pap per self throughout night. Oxygen saturation @ (at) 4:30 a.m. was 70% RA (room air). Applied PRN oxygen via nasal cannula @ 4 L.(liters) Neb (nebulizer) treatment completed. Oxygen increased to 96%. Oxygen saturation at this time 98% with 4 L oxygen." On 2/17/16, at 4:03 p.m. "Fax returned from Dr...to start Azithromycin as ordered & monitor for allergy. (Name of pharmacy) notified. On 2/19/16, at 10:11 a.m, "Res (resident) ill today wt (weight) not done." A subsequent notation at 11:39 a.m. included, "resident's family member in to visit today, has concerns regarding resident medications. Discovered antibiotic had not been started r/t allergy concern. Upon visiting with daughter discovered allergy to erithromycin is an intolerance not a true allergy. Zithromycin started this am (morning) and prednisone started on 2/18/16. Pt has a hoarse voice, congested tight cough, very dm (diminished) lung sounds from mid lobe down no real air flow heard. Upper lobes clear. Resident sats 90-91% with 2 liters of oxygen. Resident frequently removes oxygen and sat drops to 87-88%. does not appear to have dyspnea and denies shortness of breath (sob). Appears ill looking. Temp 99.9... Fax sent to Dr...with above info (information) and daughter notified." On 2/19/16, at 11:51 a.m. "called and spoke with daughter about fax to doctor, discussed lung sounds, low grade temp and resident not leaving oxygen on. Discussed she is not sob (short of breath) at this time. Daughter asked if she may have pneumonia discussed it is possible but would need to see a doctor to determine this. She wants to just see how it goes for now. Discussed	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 8 resident can be seen at clinic if she changes her mind. Call placed to (pharmacy name) to inform of allergy. On 2/19/16, at 2:24 p.m. the notes included, "1330 (1:30 p.m.) MD returned faxed with orders to admit to hospital. Daughter...notified et (and) in agreement- Fax sent to transfer per ambulance. Ambulance notified...Daughter here et resident transferred at 1400 (2 p.m.)..." During interview on 3/08/16, at 3:19 p.m. licensed practical nurse (LPN)-A stated she had received the message from the pharmacy regarding R2's allergy to Azithromycin and had sent a fax to the physician related to the concern about the allergy. During review of R2's medical record it was verified LPN-A had sent a fax to the clinic on 2/16/16 to inform the physician of the resident's allergy. However, the fax had been sent to the clinic after hours while the clinic was not open, thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes. LPN-A stated she'd sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A further clarified she had not considered sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day. When interviewed on 3/8/16, at 1:47 p.m. the pharmacy consultant stated the facility should have contacted the physician to identify whether a different medication would be appropriate as the pharmacy would not typically contact the physician. The pharmacy consultant stated the	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 9	2 265		

facility could have questioned the use of an alternative medication and should have had the physician send the pharmacy an order to indicate he wanted to go ahead and use the Azithromycin, and the pharmacy would have filled the prescription.

When interviewed on 3/8/16, at 3:25 p.m. the DON and the administrator verified there should have been a more timely follow up regarding the antibiotic prescribed by the physician.

When interviewed on 3/10/16, at 9:00 a.m. F-A stated LPN-B had informed F-A on the morning of 2/19/16 while she was visiting R2, that R2 had not received the medication (Azithromycin) as prescribed by the physician. F-A stated if she (F-A) hadn't brought the concern to the DON's attention she was not sure it would have been taken care of. F-A reiterated that if R2 had received the medication as ordered, she (F-A) felt the hospitalization could potentially had been prevented.

When interviewed on 3/10/16, at 12:35 p.m. LPN-B stated she recalled having asked F-A about the Azithromycin allergy for R2 on Saturday morning [2/13/16] and F-A identified there was not an allergy but an intolerance instead.

The facility's policy Notification of Change in Resident Health Status, revised 11/11/15, identified the facility would consult with the resident's physician, nurse practitioner or physician assistant, and family when:

A. An accident occurred which resulted in injury and required potential for physician intervention.
B. Acute illness or a significant change in the resident's physical, mental, or psychological

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 10 status (i.e. deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications. C. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. Depending on nursing assessment appropriate notification may be immediate (defined in policy as soon as possible no longer than 24 hours) to 48 hours. D. A decision to transfer or discharge a resident. E. expected or unexpected deaths. The facility failed to promptly contact R2's physician to inform him of the identified allergy alert to the prescribed Azithromycin. When the pharmacy declined to fill the prescription without the physician's approval, in lieu of contacting the on-call physician, staff sent a fax to the resident's physician. The clinic was closed for the day when the fax was sent, therefore intiation of an antibiotic to treat R2's URI was delayed. When staff finally received notice from R2's physician that the Azithromycin should be administered, the medication was still not administered for an additional two days. R2 was hospitalized due to a declining respiratory status, URI, for which the antibiotic had been originally ordered. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and medical director could develop and implement a policy and procedure for notification of family and physician related to significant resident conditions for which treatment is required. The DON could educate all nursing staff to the policy. The quality assessment and assurance committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION:	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 11 Twenty-One (21) days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observations, interview and document review the facility failed to revise the plan of care for 1 of 4 residents (R5) who was reviewed for pressure ulcers. Findings include: During observations of positioning on 3/8/16, at 1:54 p.m. R5 was observed lying on her right side with her right ear resting on the bed pillow. During a observation on 3/9/16, at 7:12 p.m. R5 was observed to be sleeping in her recliner with both her feet resting on the foot rest; without heel protector on nor feet elevated on a pillow.	2 555	Corrected	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 12 During a observation on 3/9/16, at 1:07 p.m. it was observed R5's outer right ear had a bloody scabbed area. At that time, R5 indicated she noted a sore on her right ear prior to admission on 12/11/15. R5 further revealed she obtained the sore by laying on her oxygen tubing. Review of the weekly skin review dated 3/1/16, indicated R5 was identified with a reddened right ear (no measurements). Review of the wound evaluation dated 3/3/16, identified right ear measurements to be 0.5 cm length and 1.0 cm width with an intervention that included a neck pillow. Review of the weekly skin review dated 2/23/16, R5 was identified with a pressure ulcer to the right heel. Review of the wound evaluation dated 3/3/16, identified the left heel measurement to be 2.0 cm length by 2.5 cm width with an intervention that included a heel protector to the left heel. 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 During an interview on 3/09/2016, at 7:04 p.m. director of nursing (DON) verified the care plan had not been revised to include interventions related to R5's pressure ulcers to the right ear and left heel; which included a neck pillow to the	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 13 right ear and heel protector to the left heel. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 2 of 4 residents (R2, R5) reviewed who were identified at risk for pressure ulcer development and had facility acquired pressure ulcers and for 1 of 3 residents (R1) reviewed who required assistance with grooming. Findings include: R43 was admitted on 12/28/15 with diagnoses listed on his active care plan that included:	2 565	Corrected	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 14 anemia, depression, anxiety, vertebral fractures, repeated falls and heart failure. On 2/15/16 family elected hospice services related to diagnosis end stage liver cirrhosis. When interviewed on 3/7/16, at 10:39 a.m. the registered nurse (RN) case manager stated R43 had a Stage III pressure ulcer on the sacral region which had developed while R43 was a resident at the facility. R43's care plan dated 3/9/16, identified: skin concern with potential for alteration in skin integrity related to weakness, cognitive communication deficit, urinary dribbling/incontinence, bowel incontinence, cirrhosis of the liver, edema, anemia, decreased appetite/intakes, history moisture associated skin breakdown, history of pressure ulcers, and admitted with a stage I coccyx decub. Interventions included on the care plan included: 1.) Air overlay mattress on bed- pressure relieving cushion in geri-chair; 2.) Braden scale quarterly; 3.) Daily decub monitoring; 4.) Encourage food & fluid intakes; 5.) Encourage to be up & as active as possible; 6.) Monitor and report signs of skin breakdown; 7.) Provide pericare after incontinent episodes; 8.) Skin assessment weekly; 9.) Tissue tolerance testing; 10.) Treatment to altered skin site per M.D. order; 11.) Turn/reposition and/or off-load every hour; 12.) Weekly decubitus update; During observation on 3/9/16, at 10:38 a.m. nursing assistants (NA)- B and NA-C entered R43's room to reposition and provide incontinence care for R43. R43 was rolled onto his left side by NA-B and was noted to have a 4 x	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 15 4 foam cover located over his sacral area, and (2) 2 x 4 non-stick dressings above the sacral area. NA-B and NA-C stated R43 had open areas under each dressing and stated they were not aware of the characteristics of the wounds as they were usually positioning R43 onto his side while the nurse was providing treatment to the wounds. NA-B indicated R43 was repositioned hourly with his declining condition and a hospice aide usually came in to feed R43 lunch so they would get him up into recliner prior to lunch. R43 noted to have an air bed and bilateral heel protectors on. During observation of wound cares on 3/9/16, at 11:59 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-B performed wound cares. R43 was noted to have a large foam dressing over his coccyx region and two 4 x 4 dressings above the foam dressing on his sacrum region. The 4 x 4 dressing directly above the foam dressing was noted to have drainage. R43 was also noted to have a quarter sized Stage II PU on his coccyx, a Stage III PU of golf ball size circumference, a wound on his lower sacrum and a dime sized Stage II pressure above the sacral ulcer. RN-A cleansed each wound with wound cleanser and re-applied dressings to the wounds. 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.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	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. 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 skin intact. 4. 2/4/16 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	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 17 decub monitoring, or monitoring and reporting signs of skin breakdown as directed by the care plan. On 3/9/16, at 3:20 p.m. the facility nurse consultant was interviewed and verified there were concerns about license staff's ability to measure and assess pressure ulcers and stated staff needed more training. On 3/9/16, at 4:10 p.m. registered nurse (RN)-C was interviewed and verified during morning dressing change she observed a pressure ulcer on R43's buttocks, in his buttocks crease, approximately quarter sized, a golf ball sized open area on sacral region and a popped blister looking area, dime sized, on her supra sacral region. On 3/10/16, at 6:58 a.m. licensed practical nurse (LPN)-B was interviewed and stated she worked with R43 either on 3/2/16 or 3/3/16, but remembers R43 had 3 open areas. LPN-B identified R43 had a wound on his coccyx, a larger sacral wound, and 1 a smaller wound above the sacral area which would correlate with what was visualized during dressing change observation on 3/9/16. On 3/10/16, at 8:33 a.m. nursing assistant (NA)-F was interviewed and stated she had worked as a NA with R43 the previous week and R43 had a foam dressing and two additional dressings on his back above the foam dressing. On 3/10/16, at 9:18 a.m. the DON entered R43's room and measured R43 wounds. R43 was identified with the following open areas. Coccyx wound in buttocks crease measured 2 cm x 1.8 cm. Sacral wound measured 2.5 cm x 2 cm.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 18 Another sacral wound on the periphery of the larger sacral wound measured 0.8 cm x 0.6 cm. The wound above the larger sacral wound measured 1 cm x 1 cm. The DNS stated she was not aware of the supra sacral or peripheral sacral wounds. The peripheral sacral wound had not been noted in any documentation. On 3/7/16, at 11:11 a.m., and 3/8/16, at 2:09 p.m. R1 was observed in his room with long, jagged fingernails with dark brown debris noted underneath the fingernails on both hands. On 3/09/16, at 4:16 p.m. R1 was observed lying in bed while in his room and continued to have long, jagged fingernails with brown residue present under the nails. R1 confirmed his fingernails were long and soiled and stated the facility had a class approximately once a week where they soak the nails to clean them and will also file/trim and put polish on the nails. When asked whether staff offer to clean his fingernails in between and he responded, "no." When asked whether he would allow staff to clean and trim his fingernails, R 1 responded affirmatively. Review of R1's eTAR (electronic treatment administration record) dated March 2016 included: "clean, trim and file finger and toe nails the 15th & 30th of every month. [sic] in the morning every 14 day(s)." The care plan dated 3/1/16, identified an alteration in self care with interventions including: "assist with nail care". When interviewed on 3/10/16, at 10:50 a.m. nursing assistant (NA)-A stated the nurses were responsible for trimming R1's nails as he is diabetic. NA-A confirmed the NA's assist with cleaning R1's nails in between and that R1 was cooperative with assistance with ADL's.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 19 When interviewed on 3/10/16, at 1:30 p.m. the director of nursing (DON) confirmed NA's were responsible for resident nail care and that the licensed nurses were responsible for trimming R1's nails. The DON verified the NA's should still be cleaning R1's nails and also could file R1's nails as necessary. DON observed R1's fingernails with surveyor and confirmed they were long and soiled. DON stated she would have expected R1's nails to be trimmed by nursing staff per the eTAR (trim on 15th and 30th of each month) and would have expected NA's to clean and file R1's nails as needed per the plan of care. R5 was admitted on 12/11/15, following a 9 day hospital stay for recurrent pleural effusion on right side (fluid accumulation in the lung). R5 has other diagnoses that include diabetes mellitus II (DM II), osteoarthritis, myocardial infarction (heart attack) and heart failure. R5's care plan initiated on 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. During an observation on 3/9/16, at 4:53 p.m. licensed practical nurse (LPN)-B measured and applied treatment to the left buttock pressure ulcer. The ulcer was observed to be 2.6 centimeters (cm) by 2.0 cm with a depth of 0.3 millimeters. The pressure ulcer was identified to have rolled edges and a gray wound bed with a	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 20 large area of redness surrounding it. During an interview 3/9/16, at 1:00 p.m. R5 reported that she got the sore on her bottom long before she fell [2/7/16]. R5 stated that when staff assisted with personal care she informed them it was sore; they told her she had an open area. R5 stated, "They would put some cream on it and that's all they did. Now its covered. It's still pretty sore and tender. It hurts to sit on it too long so that is why they lay me down often". Documentation revealed the weekly skin assessments did not include wound measurements to monitor progress/decline as part of the weekly skin assessments as identified in the care plan. Documentation in the nursing progress notes dated 1/22/16, identified R5 as having a dark reddened blistered area on left side of buttocks which measured 4.0 cm by 2.0 cm, the area was tender to touch and had previously been treated with barrier cream. Progress notes dated 1/26/16, indicated blistered area on left side of buttocks appeared to have popped and oozed serosanguineous drainage (watery bloody drainage), but no measurement taken. Further review of the nurse progress note for 2/27/16 indicated a dressing was changed on coccyx and identified the ulcer increased in size and was odorous; no measurement. The documentation also noted the wound had yellow edges with a dark center. R5 indicated it hurt more lately. Review of the weekly skin review dated 2/2/16, indicated an open area on buttocks, healing slowly but not measured. The weekly skin review dated 2/23/16, indicated areas on buttocks currently covered with patches with no measurements. The weekly skin review dated 3/1/16, indicated R5 had open areas to coccyx	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 21 (no measurements taken). The weekly skin assessment dated 3/8/16, indicated open areas on buttocks only, not measured. Although, the plan of care included weekly skin assessments and an interventions which included skin monitoring, this had not been implemented for R5's left buttock PU (identified on 1/22/16) as the wound had not been measured consistently to indicate whether healing occurred . In addition, since the weekly skin assessments lacked consistent monitoring and measurement of the wound, it was difficult to determine the status of the PU. When interviewed on 3/10/16, at 8:15 a.m. the director of nursing (DON) verified the pressure ulcer on the left buttock should have been appropriately measured and monitored, including measurements so the healing progress could be assessed. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures for following the comprehensive care plans, develop and provide education pertaining to following the care plan, and review standards of nursing documentation and monitoring for for any impaired skin integrity issues. The facility could then develop and implement and auditing system as part as quality assurance to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision	2 570		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 22 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observations, interview and document review the facility failed to revise the plan of care for 1 of 4 residents (R5) who was reviewed for pressure ulcers. Findings include: During observations of positioning on 3/8/16, at 1:54 p.m. R5 was observed lying on her right side with her right ear resting on the bed pillow. During a observation on 3/9/16, at 7:12 p.m. R5 was observed to be sleeping in her recliner with both her feet resting on the foot rest; without heel protector on nor feet elevated on a pillow. During a observation on 3/9/16, at 1:07 p.m. it was observed R5's outer right ear had a bloody scabbed area. At that time, R5 indicated she noted a sore on her right ear prior to admission on 12/11/15. R5 further revealed she obtained the sore by laying on her oxygen tubing. Review of the weekly skin review dated 3/1/16,	2 570	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 23 indicated R5 was identified with a reddened right ear (no measurements). Review of the wound evaluation dated 3/3/16, identified right ear measurements to be 0.5 cm length and 1.0 cm width with an intervention that included a neck pillow. Review of the weekly skin review dated 2/23/16, R5 was identified with a pressure ulcer to the right heel. Review of the wound evaluation dated 3/3/16, identified the left heel measurement to be 2.0 cm length by 2.5 cm width with an intervention that included a heel protector to the left heel. 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 During an interview on 3/09/2016, at 7:04 p.m. director of nursing (DON) verified the care plan had not been revised to include interventions related to R5's pressure ulcers to the right ear and left heel; which included a neck pillow to the right ear and heel protector to the left heel. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 24 revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate nursing care and services for 1 of 1 resident (R2) reviewed who had been hospitalized. This resulted in actual harm for R2, who experienced diminished lung sounds, thick yellow sputum and a tight congested cough related to delayed nursing assessment, delayed notification of the family and physician, delayed administration of antibiotic treatment and subsequent transfer to an inpatient facility due to respiratory difficulties. In addition, the facility failed to consistently assess and	2 830	Corrected	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 25 document monitoring of pain for 1 of 3 residents (R32) reviewed who experienced pain. Findings include: When interviewed on 3/7/16, at 2:35 p.m. via telephone, R2's family member (F)-A was questioned about notification by staff when a significant change in the resident's physical health or status occurred. 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 administered the medication as ordered. When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 26	2 830		

pharmacy alert by 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]. There was no further documentation in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family was first made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy.

When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 27 antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms. The following progress notes were recorded in R2's medical record: On 2/12/16 at 12:00 p.m., "...This nurse went into room and noted resident lying in bed audible wheeze heard. 2+ edema noted to bilateral feet. Resident has frequent non productive cough when lying down. Resident has had frequent episodes with edema to bilateral feet...VS (vital signs) obtained and lung sounds listened to per stethoscope and noise noted in right lobes where left lobes sounded diminished. Resident denies feeling ill. Fax sent to MD (medical doctor) and daughter to be notified when she comes in facility." On 2/13/16 at 5:29 p.m., family approached this nurse tor report [R2] was not waking up today and not transferring well. The note indicated the family had also reported R2 had a frequent cough. The documented note included, "Residents condition has changed this week. She has been more difficult to transfer and has had more edema to feet and more cough... Lung sounds diminished in right and sounds noted in left. Frequent cough noted. Call placed to Dr. (doctor) on call at hospital and order received for Duoneb's q (every) 4 hours prn (as needed) and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 28 for Prednisone 60 mg (milligrams) po (orally) today and tomorrow and to check with Dr... on Monday..." An undated note documented on the back side of the progress notes included, "On 2/16, resident returned from seeing Dr ...at clinic. New orders were for Azithromycin 500 mg first dose then 250 mg daily x 4 days. Order was sent to (name of pharmacy). They returned the order stating residnet had an allergy to this medicine & double check with Doctor. Resent to Dr...& returned stating start & monitro for reaction. This was again faxed to (name of pharmacy). On Thursday morning (name of pharmacy) calls to see what was happening with order. I stated that I sent it last night, where upon she asked me to fax it again, with the promise that it would be sent out on that evening run. Order was left on med cart to be put in MAR (medication administration record) once the medicine arrived. The EDU E-kit (emergency medication kit) was checked for a supply of this med, & had only had one pill of 250 mg in stock." On 2/17/16 at 5:37 a.m., "Resident removed C-Pap per self throughout night. Oxygen saturation @ (at) 4:30 a.m. was 70% RA (room air). Applied PRN oxygen via nasal cannula @ 4 L.(liters) Neb (nebulizer) treatment completed. Oxygen increased to 96%. Oxygen saturation at this time 98% with 4 L oxygen." On 2/17/16, at 4:03 p.m. "Fax returned from Dr...to start Azithromycin as ordered & monitor for allergy. (Name of pharmacy) notified. On 2/19/16, at 10:11 a.m, "Res (resident) ill today wt (weight) not done." A subsequent notation at 11:39 a.m. included, "resident's family member in	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29 to visit today, has concerns regarding resident medications. Discovered antibiotic had not been started r/t allergy concern. Upon visiting with daughter discovered allergy to erithromycin is an intolerance not a true allergy. Zithromycin started this am (morning) and prednisone started on 2/18/16. Pt has a hoarse voice, congested tight cough, very dm (diminished) lung sounds from mid lobe down no real air flow heard. Upper lobes clear. Resident sats 90-91% with 2 liters of oxygen. Resident frequently removes oxygen and sat drops to 87-88%. does not appear to have dyspnea and denies shortness of breath (sob). Appears ill looking. Temp 99.9... Fax sent to Dr...with above info (information) and daughter notified." On 2/19/16, at 11:51 a.m. "called and spoke with daughter about fax to doctor, discussed lung sounds, low grade temp and resident not leaving oxygen on. Discussed she is not sob (short of breath) at this time. Daughter asked if she may have pneumonia discussed it is possible but would need to see a doctor to determine this. She wants to just see how it goes for now. Discussed resident can be seen at clinic if she changes her mind. Call placed to (pharmacy name) to inform of allergy. On 2/19/16, at 2:24 p.m. the notes included, "1330 (1:30 p.m.) MD returned faxed with orders to admit to hospital. Daughter...notified et (and) in agreement- Fax sent to transfer per ambulance. Ambulance notified...Daughter here et resident transferred at 1400 (2 p.m.)..." During interview on 3/08/16, at 3:19 p.m. licensed practical nurse (LPN)-A stated she had received the message from the pharmacy regarding R2's allergy to Azithromycin and had sent a fax to the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 30 physician related to the concern about the allergy. During review of R2's medical record it was verified LPN-A had sent a fax to the clinic on 2/16/16 to inform the physician of the resident's allergy. However, the fax had been sent to the clinic after hours while the clinic was not open, thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes. LPN-A stated she'd sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A further clarified she had not considered sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day. When interviewed on 3/8/16, at 1:47 p.m. the pharmacy consultant stated the facility should have contacted the physician to identify whether a different medication would be appropriate as the pharmacy would not typically contact the physician. The pharmacy consultant stated the facility could have questioned the use of an alternative medication and should have had the physician send the pharmacy an order to indicate he wanted to go ahead and use the Azithromycin, and the pharmacy would have filled the prescription. When interviewed on 3/8/16, at 3:25 p.m. the DON and the administrator verified there should have been more timely follow up regarding the antibiotic prescribed by the physician. When interviewed on 3/10/16, at 9:00 a.m. F-A stated LPN-B had informed F-A on the morning of 2/19/16 while she was visiting R2, that R2 had not	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 31 received the medication (Azithromycin) as prescribed by the physician. F-A stated if she (F-A) hadn't brought the concern to the DON's attention she was not sure it would have been taken care of. F-A reiterated that if R2 had received the medication as ordered, she (F-A) felt the hospitalization could potentially had been prevented. When interviewed on 3/10/16, at 12:35 p.m. LPN-B stated she recalled having asked F-A about the Azithromycin allergy for R2 on Saturday morning [2/13/16] and F-A identified there was not an allergy but an intolerance instead. The facility failed to promptly contact R2's physician to inform him of the identified allergy alert to the prescribed Azithromycin. When the pharmacy declined to fill the prescription without the physician's approval, in lieu of contacting the on-call physician, staff sent a fax to the resident's physician. The clinic was closed for the day when the fax was sent, therefore intiation of an antibiotic to treat R2's URI was delayed. When staff finally received notice from R2's physician that the Azithromycin should be administered, the medication was still not administered for an additional two days. R2 was hospitalized due to a declining respiratory status, URI, for which the antibiotic had been originally ordered. It was observed on 3/7/16, at 11:33 a.m. that R32 moved her head and neck very slowly, appearing to be in pain. When interviewed at this time R32 reported experiencing pain in back, neck, and shoulders. R32 stated that she received a scheduled pain medication earlier that morning which helped with the pain. R32 then rated the current pain level "8" on a scale of 1-10.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 32 R32's quarterly Minimum Data Set (MDS) assessment dated 2/26/16, indicated intact cognition, extensive assistance with bed mobility, transfer, walk in room/corridor, locomotion on unit, dressing, and personal hygiene. The assessment further indicated R32 experienced frequent pain and was on a scheduled pain medication regimen. R32's care plan dated 2/29/16, indicated a potential for pain and discomfort related to (r/t) diagnosis (dx) of generalized pain, kyphosis (abnormally excessive rounding of the back), cervicalgia (neck pain), history of (h/o) chronic migraines, h/o chronic complaints of (c/o) right (R) arm/shoulder/neck pain, h/o abdominal pain and pain below bilateral knees. Interventions included pain assessment quarterly and prn (as needed), and to monitor and report signs of pain/discomfort. The signed physician orders dated 2/22/16, included: Tramadol HCl 50 milligrams (mg) three times a day for pain; acetaminophen [Tylenol] 325 mg every 6 hours prn for pain rating 1-5 out of 10; and acetaminophen 650 mg every 6 hours prn for pain rated 5-9 out of 10. The physician progress note dated 2/22/16 included: "At present, she still complains of a lot of pain in that right arm, which may be related to the old CVA (cerebrovascular accident/stroke) or may be related to the arthritic changes that have occurred in that right shoulder and arm. At present, we will continue to keep an eye on this and see how she does with it; indicates that it is controlled at present." On 3/09/16, at 2:19 p.m. R32 was seated in wheelchair in her room with a tray table in front of	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 33	2 830		

her listening to the television. When interviewed at that time, R32 stated her right arm was hurting and felt "out of place"; R32 expressed a pain rating of "8" out of 10. R32 then activated her call light to request to speak to the nurse. Nursing assistant (NA)-B entered the room a short time later and R32 requested to speak to licensed practical nurse (LPN)-B about the pain she was experiencing in her right arm; NA-B exited R32's room to alert the nurse.

On 3/9/16, at 2:30 p.m. when registered nurse (RN)-C entered R32's room, R32 stated her (R) arm was hurting and it felt "out of place". R32 further explained this had happened in the past and the therapist had put it back into place. RN-C asked R32 if she would like the therapist to come and assess. R32 refused and requested that LPN-B be summoned as she knew more about it; R32 then started to cry. RN-C asked R32 if she was in pain and R32 replied she was always in pain but that sometimes her arm would go out. R32 was observed with (R) arm bent at the elbow; R32 exhibited not being able to extend and straighten her (R) forearm forward. RN-C comforted the resident and stated she would have LPN-B talk with her per the resident's request.

On 3/9/16, at 2:36 p.m. LPN-B entered R32's room and questioned the resident pertaining to the (R) arm pain. R32 stated her upper arm was hurting and that she couldn't extend it out straight. R32 then exhibited how far she could stretch her (R) arm; the arm remained bent at the elbow and she was able to partially extend the forearm. R32 stated this had only happened once prior and the therapist had done something to put it back into place. LPN-B indicated being unaware R32 had that problem in the past and explained that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 34 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 the stated ineffectiveness of the prn.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 35 Further review of the eMAR dated 3/9/16, indicated R32's scheduled Tramadol 50 mg three times a day did not include a pain rating for the 4:00 p.m. dose. The pain rating for the 8:00 p.m. scheduled Tramadol dose indicated a pain rating of 9 out of 10 at the time of administration. When interviewed on 3/9/16, at 6:30 p.m. the director of nursing (DON) confirmed that administration/charting of prn medication is directly linked from the eMAR to the electronic progress notes and should include a 1-10 rating of the resident's pain. The DON further stated she would expect charting to include the location of the resident's pain. On 3/10/16, at 11:18 a.m. R32 was observed lying in bed resting. When questioned whether she was experiencing any pain. R32 denied stating, "No, because I had a pain pill." R32 further stated having pain in her (R) arm earlier when in the dining room and when reported to staff, the nurse administered a pain pill. R32 stated she continued to have the same problem as yesterday, stating her (R) arm wouldn't release at the elbow and that her (R) hand and fingers felt numb. R32 indicated that no nurse had inquired about her (R) arm today when she was administered the scheduled pain medication. Review of the eMAR dated 3/10/16, indicated R32 was given scheduled Tramadol 50 mg at 8:00 a.m. with a pain rating of 8 out of 10 at time of administration. When interviewed on 3/10/16, at 11:58 a.m. RN-B confirmed giving R32 the scheduled 8:00 a.m. Tramadol, and further confirmed the resident had c/o back and (R) arm pain rated 8 out of 10 at that time. RN-B stated the resident usually	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 36	2 830		

always reported some pain when given the scheduled Tramadol but usually rated 4-5 out of 10. RN-B stated the rating of 8 this morning and 9 last night were not typical (higher) for R32. RN-B stated R32 also had prn Tylenol available to use between scheduled doses of Tramadol for breakthrough pain. RN-B stated when administering prn medications, she would document a chart note related to the pain, but only rated the pain when administering the scheduled pain medication (Tramadol). RN-B confirmed she would not necessarily document a progress note r/t pain for the scheduled medication.

When interviewed on 3/10/16, at 12:10 p.m. LPN-B confirmed she had not documented a progress note pertaining to R32's (R) arm pain on 3/9/16 and should have done so. LPN-B further confirmed the pain R32 described in the (R) arm to her knowledge was unusual as no other staff could recall the resident c/o this sort of pain in the past. LPN-B again confirmed R32's c/o (R) arm pain should have been documented even though she had communicated the information during report.

When interviewed on 3/10/16, at 1:20 p.m. the DON confirmed she would expect prn medications to include a progress note documented by the nurse indicating the reason the medication was given, an assessment/location of the pain, pain scale rating, and follow up r/t to effectiveness.

The Pain Management Guideline effective 2/10/15, under GUIDELINE included: "Assessing pain and evaluating response to pain management interventions using a pain management scale based on patient/resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 37 self-report or objective assessment for the cognitively impaired. Documenting pain assessment and interventions prior to giving medication. Evaluation activities should be recorded in a concise manner per the plan of care. Nursing staff should utilize the electronic pain evaluation and nursing note link when it is available." Under MONITORING/COMPLIANCE included: "Documentation and observation of care and treatment reflects ongoing monitoring of pain levels and interventions (pharmacological and non-pharmacological). The documentation will be reflected on the eMAR and progress notes." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure assessment of resident conditions are conducted, and that interventions including medications, are implemented as directed. The Director of Nursing or designee could educate all appropriate staff to the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.	2 860		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide nail care for 1 of 3 residents (R1) reviewed for activities of daily living (ADLs). Findings include: On 3/7/16, at 11:11 a.m., and 3/8/16, at 2:09 p.m. R1 was observed in his room with long, jagged fingernails with dark brown debris noted underneath the fingernails on both hands. On 3/09/16, at 4:16 p.m. R1 was observed lying in bed while in his room and continued to have long, jagged fingernails with brown residue present under the nails. R1 confirmed his fingernails were long and soiled and stated the facility had a class approximately once a week where they soak the nails to clean them and will also file/trim and put polish on the nails. When asked whether staff offer to clean his fingernails in between and he responded, "no." When asked whether he would allow staff to clean and trim his fingernails, R 1 responded affirmatively. R1's quarterly minimum data set (MDS) assessment dated 2/26/16, included a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating intact cognition. The MDS also identified that R1 required extensive assistance with personal hygiene. The care plan dated 3/1/16, identified an alteration in self care with interventions including: "assist with nail care". Review of R1's eTAR (electronic treatment	2 860	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 39 administration record) dated March 2016 included: "clean, trim and file finger and toe nails the 15th & 30th of every month. [sic] in the morning every 14 day(s)." When interviewed on 3/10/16, at 10:50 a.m. nursing assistant (NA)-A stated the nurses were responsible for trimming R1's nails as he is diabetic. NA-A confirmed the NA's assist with cleaning R1's nails in between and that R1 was cooperative with assistance with ADL's. When interviewed on 3/10/16, at 1:30 p.m. the director of nursing (DON) confirmed NA's were responsible for resident nail care and that the licensed nurses were responsible for trimming R1's nails. The DON verified the NA's should still be cleaning R1's nails and also could file R1's nails as necessary. DON observed R1's fingernails with surveyor and confirmed they were long and soiled. DON stated she would have expected R1's nails to be trimmed by nursing staff per the eTAR (trim on 15th and 30th of each month) and would have expected NA's to clean and file R1's nails as needed per the plan of care. SUGGESTED METHOD OF CORRECTION: The DON could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 860		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 40 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 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 indicated the family had elected to utilize hospice	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 41 services 2/15/16 related to diagnosis end stage liver cirrhosis. During interview with the registered nurse (RN)-A on 3/7/16 at 10:39 a.m., RN-A stated R43 had a Stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss) which had developed to the sacral region while R43 was a resident at the facility. The admission Minimum Data Set (MDS) assessment dated 1/2/16, identified R43 with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also identified R43 required extensive assist with bed mobility and dressing, was dependent of staff for transfers and did not ambulate. The MDS further identified R43 with frequent bowel and bladder incontinence and a Stage I pressure ulcer (a defined area of persistent redness in lightly pigmented skin). Progress notes documented in R43's medical record identified the following: -12/31/15 Resident has redness on buttocks. Small (1 centimeter (cm) x 1.5 cm) opening on coccyx; foam dressing in place. Superficial at this time. Will continue to monitor. -12/31/15, at 1:51 p.m. Resident is incontinent of bowel & bladder. He is checked and changed routinely. Has no scheduled treatments but coccyx has red area noted, Mepilix (an absorbent, atraumatic dressing made from polyurethane foam) applied for preventive measures. No restraints used as resident is unable to move per self. Needs extensive assist	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 42 with all ADL's (activities of daily living) - unable to do anything per self at this time. -1/1/16, at 2:23 p.m. called to room by NAs (nursing assistants) - resident's coccyx has two open areas noted which started as blisters that have broken open, tegaderm foam adhesive dressing applied, staff will reposition resident to keep off area when in bed. Will fax doctor tomorrow as today 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 received with order to place a tegaderm to open 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, -1/14/16, at 10:30 a.m. has history of a pressure ulcer on his right (R) elbow during prior facility admission, that has healed. Current interventions include an air overlay mattress on his bed, a pressure relieving cushion on his geri-chair, a check and change program for optimal dryness and cleanliness, scheduled turning/repositioning every (q) 2 hours, and use of air filled pressure relieving boots to both legs/feet. -1/16/16, at 12:46 p.m. Requires assist of 2 staff members with cares and with repositioning due to pain issues. Tegaderm in place to coccyx and staff changes that q day. Requires total assist with feeding and with cares. Is repositioned q 2	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 43 hours due to pressure area. -1/24/16, at 10:39 p.m. Total dependence with all ADLs. Difficult to dress related to shoulder. Incontinent of bowel and bladder. Area on coccyx is draining serosanguineous drainage. Buttocks remain red. -1/25/16 1:55 p.m. Receives PT/OT/ST (physical therapy, occupational therapy, speech therapy) 5 x/week for strengthening. Coccyx area is very excoriated and tender, Carona (non-stick gel dressing) applied. 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. The 3/9/16 care plan for R43 identified: skin concern with potential for alteration in skin integrity related to weakness, cognitive communication deficit, urinary dribbling/incontinence, bowel incontinence, cirrhosis of the liver, edema, anemia, decreased appetite/intakes, history moisture associated skin breakdown, history of pressure ulcers, admitted with a stage I coccyx decubitus. Care Plan interventions included: (1.) Air overlay mattress on bed, (2) pressure relieving cushion in geri-chair, (3) Braden scale quarterly, (4) Daily decub (decubitus ulcer) monitoring, (5) Encourage food & fluid intakes, (6) Encourage to be up & as active as possible, (7) Monitor and report signs of skin breakdown, (8) Provide pericare after incontinent episodes, (9) Skin	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 44 assessment weekly, (10) Tissue tolerance testing (assessment of the tolerance of the resident's tissue to prolonged pressure), (11) Treatment to altered skin site per M.D. (medical doctor) order, (12) Turn/reposition and/or off-load every hour, and (13) Weekly decubitus update During observation on 3/9/16, at 10:38 a.m. NA-B and NA-C entered R43's room to reposition and provide incontinence care for R43. R43 was rolled onto his left side by NA-B and was noted to have a 4 x 4 foam dressing located over his sacral area, and two 2 x 4 non-stick dressings above the sacral area. NA-B and NA-C stated R43 had open areas under each dressing and stated they were not aware of the characteristics of the wounds as they were usually positioning R43 onto his side while the nurse was providing treatment to the wounds. NA-B stated R43 was repositioned hourly due to his declining condition. NA-B also stated a hospice aide usually came in to feed R43 lunch so they would get R43 up into his recliner prior to lunch. During this observation, R43 was noted to have an air bed and bilateral heel protectors on. R43's current physician orders identified treatments that included: 1. Calcium alginate with silver wound dressing following wound cleanser then cover with Allevyn and tegaderm every 5 days and PRN; 2. Foam dressing to area on right hip where resident is scratching, change as needed; 3. Bilateral air filled pressure relieving boots on at all times, except for bathing; 4. Turn/reposition and/or off-load every one hour. During observation of wound cares on 3/9/16, at 11:59 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-B performed wound cares.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 45 R43 was noted to have a large foam dressing over his coccyx region and two 4 x 4 dressings above the foam dressing on his sacrum region. The 4 x 4 dressing directly above the foam dressing was noted to have drainage. R43 was also noted to have a quarter sized Stage II PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) on his coccyx, a Stage III PU of golf ball size circumference, a wound on his lower sacrum and a dime sized Stage II pressure above the sacral ulcer. RN-A cleansed each wound with wound cleanser and re-applied dressings to the wounds. 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. The weekly skin assessments documented in the record were incomplete and/or inaccurate as they did not correlate with the MDS assessments and the wound evaluation flowsheet documentation. The following was noted on the weekly skin assessments:. (1.) 1/14/16- identified coccyx- no description of wounds. (2.) 1/21/16- identified open areas on coccyx but no details of characteristics. (3.) 1/28/16 -identified skin intact; (wound flowsheet identiied unstageable and Stage I) (4.) 2/4/16-identified a large open area on	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 46 coccyx; multiple open areas on bilateral buttocks; and dressings in place. 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. There was a discrepancy between the wound evaluation flowsheets documentation and the nursing progress notes. The documentation revealed inconsistent assessments of the condition of R43's skin. A 3rd PU located on R43's sacrum was identified on 3/9/16, which measured 0.5 cm x 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. When interviewed on 9/9/16, at 1:00 p.m. the director of nursing (DON) stated she was unaware that R43 had 3 PU's. The DON stated she realized there was some inconsistency in assessing pressure ulcers due to lack of training of some of the licensed staff. When interviewed on 3/9/16, at 3:20 p.m. the facility nurse consultant verified there were concerns about license staff's ability to measure and assess pressure ulcers and stated staff needed more training. On 3/9/16, at 4:10 p.m. RN-C was interviewed and verified during morning dressing change she observed a PU on R43's buttocks, in the buttocks	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 47 crease, approximately quarter sized, a golf ball sized open area on sacral region and a popped blister looking area, dime sized, above the sacral wound. On 3/10/16, at 6:58 a.m. LPN-B was interviewed and stated she worked with R43 either on 3/2/16 or 3/3/16, but remembers R43 had 3 open areas. LPN-B identified R43 had a wound on his coccyx, a larger sacral wound, and 1 a smaller wound above the sacral area which was the same area observed during dressing 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. On 3/10/16, at 9:18 a.m. the DON measured R43 wounds and identified the following 4 open areas: #1-coccyx wound in buttocks crease measured 2 cm x 1.8 cm.; #2-sacral wound measured 2.5 cm x 2 cm.; #3-additional sacral wound on the periphery of the larger sacral wound measured 0.8 cm x 0.6 cm.; and #4 wound located above the larger sacral wound measured 1 cm x 1 cm. The DON stated she was not aware of the supra sacral or peripheral sacral wounds. The peripheral sacral wound had not been noted in any documentation found in the medical record. Throughout review of R43's medical record it was noted there was inconsistent tracking, accuracy of reporting or ongoing monitoring of pressure ulcers even when R43 was identified at high risk related to his long history of pressure ulcer development. The medical record failed to accurately identify wounds or show continuous monitor to reduce R43's risk of further development or deterioration of current pressure	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 48 ulcers. R43 had developed four (4) stage II or greater pressure ulcers since his admission to the facility and continued to show risk for ongoing deterioration and breakdown. The wound on R43's sacrum was evaluated on 1/28/16, as a 1 cm x 1.5 cm wound and not evaluated again until 3/4/16 when it had progressed to a 2.3 cm x 2.1 cm open pressure ulcer. There was evidence R43 sustained harm related to the facility's failure to accurately monitor the progression of wounds and R43 remained at risk for development of further pressure ulcers as noted by the development of the fourth pressure ulcer during the survey. R5 was admitted on 12/11/15, following a 9 day hospital stay for recurrent pleural effusion on right side (fluid accumulation in the lung). R5 has other diagnoses that include diabetes mellitus II (DM II), osteoarthritis, myocardial infarction (heart attack) and heart failure. R5 requires blood sugar checks and insulin based on a sliding scale. The blood sugars were usually high with some lows ranging from 57-549 with frequent insulin adjustments made by the physician. R5 had a fall at the facility on 2/7/16, sustained multiple left pelvic fractures and a left fracture to elbow and was subsequently hospitalized until 2/11/16 when re-admitted to the facility. The Minimum Data Set (MDS) dated 2/18/16, R5 required extensive assistance with bed mobility and transferring. During observations of positioning on 3/8/16, at 1:54 p.m. it was noted R5 was lying on her right side with her head and right ear directly on the pillow. During an observation on 3/9/16, at 1:07 p.m. it was noted that R5's outer right ear had a bloody scabbed area. At that time, R5 indicated she	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 49 noted the sore area prior to admission in December and explained she received it from laying on her oxygen tubing. During an observation on 3/9/16, at 4:53 p.m. licensed practical nurse (LPN)-B measured and applied treatment to the left buttock PU. The wound was observed to be 2.6 centimeters (cm) by 2 cm with a depth of 0.3 millimeters, had rolled edges, gray wound bed with a large area of redness surrounding it. The heel ulcer was observed to be a large reddened area that LPN-B reported was soft when pressure applied. LPN-B did not measure the heel wound and verified it was no longer a blistered area. On 3/9/16, at 7:12 p.m. R5 was noted to be sleeping in her recliner 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 open areas or pressure ulcers. Review of the nurse progress notes dated 1/22/16, identified R5 as having a dark reddened blistered area on left side of buttocks which measured 4 cm by 2 cm, was tender to touch and had previously been treated with barrier cream. A notification was sent to the physician on 1/22/16. When reviewing the weekly skin assessments, R5's skin was identified as intact with no areas of redness until the 1/26/16, even though it was identified on the left buttock as noted in the nurse progress notes. In contrast, the nurse progress note dated 1/26/16, indicated that a blistered area on left side of buttocks appeared to have popped and oozed serosanguineous drainage (watery bloody drainage), but no measurement taken.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 50 Review of the weekly skin assessment dated 2/2/16, indicated an open area on buttocks, healing slowly but not measured. On 2/5/16, R5's physician made a clinical visit to facility and ordered a foam tegaderm dressing to the sacral wound to be changed every 3 days and as needed. Review of the weekly skin assessment dated 2/23/16, indicated areas on buttocks currently covered with patches and newly identified red area on the left heel, neither were measured. Review of the nurse progress note for 2/27/16, indicated the dressing was changed on coccyx and had increased in size and was odorous. It also noted that wound had yellow edges with a dark center. R5 indicated it hurt more lately. Review of the weekly skin assessment dated 3/1/16, indicated R5 had an open areas coccyx and right ear (no measurements taken). No further reassessments were available for review in the record nor when requested from staff. Review of the Wound evaluation form dated 3/3/16, the flowsheet indicated PU's were facility acquired and were located on the left heel, left buttock and right ear. Measurements were noted. A fax was sent to the physician regarding the ulcer on coccyx, the reddened right ear and the blister on back of left heel. Physician orders were received 3/4/16, to treat all 3 areas. Further review of the right ear wound evaluation noted the ear was a Stage II, open, painful and tender to touch. Review of the weekly skin assessment dated 3/8/16, indicated open area on buttocks only, not	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	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 2/17/16, 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 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. Review of the Tissue tolerance observance was completed 12/16/15, and indicated R5's skin was	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	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 interventions 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 medication record nor had not been initiated. The	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 53 DON was unaware the ear was open with bloody scabbing. She further verified there were no interventions put into place to relieve pressure from the ear while R5 was lying in bed. During an interview on 3/8/16, at 1:12 nursing assistant (NA)-C indicated R5 was not on a turning schedule stating "she lets us know. We lay her down and toilet when she asks. We are doing something with her 6 times a day". During an interview 3/9/16, at 1:00 p.m. R5 reported that she got the sore on her bottom long before she fell [2/7/16]. R5 stated that when staff assisted with personal care she informed them it was sore; they told her she had an open area. R5 stated, "They would put some cream on it and that's all they did. Now its covered. It's still pretty sore and tender. It hurts to sit on it too long so that is why they lay me down often". During an interview on 3/9/16, at 7:04 p.m. DON verified the treatment was not documented on the TAR as ordered by the physician nor were interventions noted on the care plan and aid worksheets. The identified wound ulcers were documented as follows: Left buttock measurements (identified 1/22/16): 1/22/16- length 4 cm, width 2 cm, no depth reddened blister area; 2/13/16-length 2.4, width 1 cm; Undated wound evaluation week 1: 2.4 cm, width 1 cm, no depth, Stage I 3/3/16-Wound evaluation wk 2: length 2 cm, width 2.5 cm, no depth Unstageable Heel measurements (identified 2/23/16): 3/3/16-length 2 cm, width 2.5 cm.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 54 Ear measurements (identified 3/1/16): 3/3/16-length 0.5 cm, 1 cm width, no depth Throughout review of R5's medical record it was noted there was not consistent tracking, accuracy of reporting nor ongoing monitoring of PU's even when R5 was identified at high risk for PU development. The medical record documentation did not accurately and consistently identify all of the wounds nor or did it demonstrate continuous monitoring to reduce R5's risk of further development or deterioration of current pressure ulcers. The Weekly Skin Review policy dated 5/1/15, directs skin alteration findings to be identified, use the figures provided, describe type of alteration and location. It further directs a wound evaluation flow was to be initiated/updated, the MD/NP were to be notified and care plans were to be updated with new interventions. A policy related to pressure ulcer was requested and not submitted. The wound on R5's left coccyx was documented on 1/26/16 as an open blistered area 4 cm by 2 cm and not evaluated again until 3/3/16, when it had progressed to a 2.5 cm x 2 cm open pressure ulcer. There was evidence R5 sustained harm related to the facility's failure to accurately assess and monitor the progression of identified wounds. R5 remained at risk for development of further pressure ulcers as noted by the development of the left heel and right ear pressure ulcer. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedure to ensure residents have a comprehensive assessment of their risk for	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 55 developing pressure ulcers so that individualized interventions could be implemented. The Director of Nursing or her designee could educate all appropriate staff on the polices and procedures related to pressure ulcers. The Director of Nursing or her designee could develop a monitoring system to ensure residents are assessed and appropriate interventions implemented, to prevent the development of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 900		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 56 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 3 of 5 newly admitted residents (R5, R9, R43) had a tuberculosis (TB) symptom screening completed upon admission as required per State guidelines. Findings include: R5 was admitted on 12/11/15. The medical record lacked documentation of a completed TB symptom screening upon admission as required per State guidelines. R9 was admitted on 12/29/15. The medical record lacked documentation of a completed TB symptom screening upon admission as required per State guidelines. R43 was admitted on 12/28/15. The medical record lacked documentation of a completed TB symptom screening upon admission as required per State guidelines. When interviewed on 3/8/16, at approximately 10:00 a.m., the director of nursing (DON) verified R5, R9, and R43's TB symptom screening form was blank and was not completed upon admission and should have been. The policy titled, Tuberculosis, Screening Residents for effective 12/1/14 included: "The facility will screen referrals for admission and readmission for information regarding exposure to, or symptoms of, TB and will check results of recent (within 12 months) tuberculin skin tests (TST), blood assay for Mycobacterium tuberculosis (BAMT) or chest X-rays (CXR)."	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 57 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, could review and revise policies and procedures for TB surveillance. The administrator, director of nursing, could monitor resident and TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to properly label and store medications to ensure safe administation of medications. This has the potential to affect any of the 38 residents who reside in the facility. Findings include: During the medication pass on 3/9/16, at 4:22 p.m. licensed practical nurse B (LPN-B) was observed preparing medications for R2. R2 was scheduled to receive a Symbicort inhaler. The Symbicort inhaler did not have a medication label on it. LPN-B then retrieved a new inhaler that did have a label on it before administering the medication. During inspection of the north/south cart the following medications were found without labels:	21620	Corrected	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 58 Liquitears 1.4% eye drops 3 bottles, Systane eye drops 3 bottles, Timolol eye drops 0.5% 1 bottle, and Lantaprost 0.0005% eye drops 1 bottle. In addition, an open bottle of Oxyfloxin 0.3% eye drops was noted with R15's name written on the bottle. The label on the bottle said E-Kit 1/31/16. The medication was ordered 2/2/16 and discontinued 2/8/16. A medication card of Mucinex 600 mg with 9 pills remaining in the card was evident and no label was on the medication. During interview with LPN B on 3/9/16, at 4:22 p.m. she verified that R2's inhaler should have had a label on it. On 3/10/16, at 10:31 a.m. LPN-B stated she did not know why the Mucinex was stored in the cart and indicated she did not know whether it was a stock medication or an individual prescription for a resident. When interviewed on 3/10/16, at 10:56 a.m. the director of nursing (DON) verified the discontinued Oxyfloxin eye drops for R15 should have had a label and been discarded when discontinued. She also verified that all eye drops should have the appropriate labels with the resident's name. The policy PRODUCT LABELING AND PACKAGE TYPES revised 5/13/15, identified "All medication orders dispensed by the Pharmacy are labeled in accordance with all Federal and State regulations." Procedures: A. Medications dispensed to residents are appropriately and safely labeled. The label shall have: 1. Any labeling that is consistent with law, regulation and professional practice 2. Expiration dates of a maximum of one year	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 59 or the manufacturer's original date, whichever is less 3. Any applicable or cautionary statements SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to medication labeling requirements. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21620		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the	21980		4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 60 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the administrator and State Agency (SA) of an alleged violation of neglect for 1 of 3 residents (R2) for whom an allegation of neglect was reviewed. Findings include: The facility's Abuse /Neglect policy, Vulnerable	21980	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 61 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 administered the medication as ordered. When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 62	21980		

prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by 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 in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON also stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family had first been made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy.

When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 63 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms. During review of R2's medical record it was verified a fax had been sent to the clinic on 2/16/16 to inform the physician of the allergy. However, the fax was sent to the clinic after hours when the clinic was not open thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes. When interviewed on 3/8/16, at 2:23 p.m. the DON stated this issue had not been reported to the State agency and/or the administrator in accordance with the facility policy. During interview with licensed practical nurse (LPN)-A on 3/8/16, at 3:19 p.m., LPN-A stated she sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient concerns when it was not their patient." LPN-A stated she did not consider sending the fax to an	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 64 on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure all staff are aware of the importance of immediate reporting. They could establish a system to audit to ensure all allegations are properly reported in accordance with facility policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse/Neglect policy to ensure immediate reporting of allegations of potential neglect of treatment to the State Agency (SA) for 1 of 3 residents (R2) reviewed. Findings include:	21995	Corrected	4/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 65 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 administered the medication as ordered.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 66 When interviewed on 3/8/16 at 12:48 p.m., the director of nursing (DON) confirmed R2 had been prescribed Azithromycin to treat an upper respiratory infection (URI) [2/17/16]. The DON stated that after the prescription had been sent to the pharmacy to be filled, the pharmacy had notified facility staff the medication was listed as an allergy for R2. The DON stated the staff had informed the physician who had responded to the pharmacy alert by 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 in the medical record related to the use of the Azithromycin until 2/19/16, when the DON conducted a physical assessment of R2 and subsequently faxed to the physician the following: R2 had "a hoarse voice, thick yellow sputum and very diminished, with little or no air flow, middle lung lobes." In addition, the fax indicated R2 had a "tight congested cough and oxygen saturation measure 87% on room air." The fax indicated R2's oxygen saturation improved to 90-91% when on oxygen. In addition, the fax identified the antibiotic had not been administered as ordered 2/17/16. In response, R2's physician ordered that R2 be admitted directly to the hospital via ambulance transport. During interview with the DON, the DON also stated F-A had been at the facility on the morning of 2/19/16, and had expressed concern about R2's condition. The DON verified that R2's family had first been made aware that R2 had not received the physician ordered antibiotic at that time. The DON stated, "the ball was dropped" on getting the medication for R2 and being persistent with the pharmacy.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 67 When interviewed on 3/8/16, at 1:32 p.m. R2's physician recalled the facility faxing him on either 2/16/16 or 2/17/16 asking about administering the Azithromycin for R2's respiratory symptoms. The physician confirmed he'd ordered staff to proceed with administering the medication and for staff to monitor for any allergy symptoms. The physician stated he'd heard nothing further until 2/19/16 when F-A contacted him to inform him the antibiotic had not been started. The physician stated after F-A had contacted him, the facility staff had contacted him to inform him R2 had been assessed with hoarseness, thick yellow sputum, and diminished to no air flow mid lobes. The physician further stated the rationale for having prescribed the antibiotic was to treat R2 as an outpatient, and the facility's failure to acquire and administer the prescribed antibiotics had attributed to R2 requiring hospitalization for five days to treat her respiratory symptoms. During review of R2's medical record it was verified a fax had been sent to the clinic on 2/16/16 to inform the physician of the allergy. However, the fax was sent to the clinic after hours when the clinic was not open thus there was no response to the fax until 2/17/16 at approximately 4:00 p.m. as documented in the progress notes. When interviewed on 3/8/16, at 2:23 p.m. the DON stated this issue had not been reported to the State agency and/or the administrator in accordance with the facility policy. During interview with licensed practical nurse (LPN)-A on 3/8/16, at 3:19 p.m., LPN-A stated she sent the fax to the clinic versus an on-call provider because it had been her experience," physicians did not like to deal with patient	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	03/10/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 68 concerns when it was not their patient." LPN-A stated she did not consider sending the fax to an on-call physician. LPN-A stated she was aware the physician would probably not get the fax until the following day. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure all staff are aware of the importance of following the facility policy for Abuse/Neglect reporting. They could establish a system to audit to ensure all allegations are properly reported in accordance with facility policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21995		