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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BQDG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00935

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245201**

2. STATE VENDOR OR MEDICAID NO. (L2) **973842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNWOOD**
(L4) **5700 EAST RIVER ROAD**
(L5) **FRIDLEY, MN** (L6) **55432**

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 **03/25/2016** (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 **54** (L18)

13.Total Certified Beds **54** (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
	54			
(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 :
Susanne Reuss, Unit Supervisor 03/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/31/2016 (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 **04/01/1975** (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): 245201

March 31, 2016

Ms. Lynn Hogendorn, Administrator
Golden Livingcenter - Lynwood
5700 East River Road
Fridley, MN 55432

Dear Ms. Hogendorn:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 22, 2016 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 31, 2016

Ms. Lynn Hogendorn, Administrator
Golden LivingCenter - Lynwood
5700 East River Road
Fridley, MN 55432

RE: Project Number S5201025

Dear Ms. Hogendorn:

On February 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2016, effective March 22, 2016 and therefore remedies outlined in our letter to you dated February 26, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

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
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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
245201 Y1	A. Building B. Wing Y2	3/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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 F0282	Correction	ID Prefix F0311	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	03/22/2016	LSC	03/22/2016	LSC	03/22/2016
ID Prefix F0314	Correction	ID Prefix F0315	Correction	ID Prefix F0332	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.25(m)(1)	Completed
LSC	03/22/2016	LSC	03/22/2016	LSC	03/22/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/22/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SR/kfd	03/31/2016	16022	3/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/11/2016

☐ 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: BQDG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00935

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(L3) **GOLDEN LIVINGCENTER - LYNWOOD**
(L4) **5700 EAST RIVER ROAD**
(L5) **FRIDLEY, MN** (L6) **55432**

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 **02/11/2016** (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

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To (b) :

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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
	54			
(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 :
Mary Capes, HFE NE II 03/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/14/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
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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

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

REVISED LETTER

Electronically delivered

March 15, 2016

Ms. Lynn Hogendorn, Administrator
Golden LivingCenter - Lynwood
5700 East River Road
Fridley, MN 55432

RE: Project Number S5201025 and Complaint Number H5201049

Dear Ms. Hogendorn:

On February 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 11, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

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

at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 22, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 11, 2016 (three months after the

identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 11, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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. An investigation of complaint H5201049 was completed and found not to be substantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the plan of care was followed regarding toileting for 2 of 2 residents (R10, R65) observed for incontinence care, 1 of 2 residents (R10) observed for repositioning and 1 of 2 residents (R37) observed for activities of daily living (ADL's). Findings include:	F 282	Resident #10 is repositioned and toileted per individual plan of care. Resident #35 facial hair has been shaved and will continue to be shaved as needed per individual hygiene plan of care. Resident #65 is toileted per individual toileting plan of care. New admissions/re-admissions will continue to be assessed for personal	3/22/16

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

Electronically Signed | 03/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 1 Review of R10's plan of care revised on 1/18/2016 indicated the following: "Alteration in elimination of bowel and bladder Functional and mixed bowel and urinary incontinence, dependence in ADL's (activities of daily living). Resident is frquently (sic) to always incontinent of bowel and bladder." Interventions included "Check Q (every) 2 hours and change PRN (as needed)". "toileting assist: Total assist of 1 staff member." The plan of care also directed staff that R10 was at risk for alteration in skin integrity, had a history of skin damage to coccyx and buttocks, and required repositioning every two hours, with assist of 1 - 2 staff. On 2/10/16 at 9:00 a.m., R10 was sitting in her room in a wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At 11:33 a.m., the Director of Nursing (DON) brought R10 to room. The DON indicated that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA)-C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred onto the bed, NA-C removed the saturated incontinence brief, and applied a new brief. Interview with NA-C at 11:47 a.m., revealed R10 was "check and change every two hours and required repositioning every two hours". NA-C indicated R10 was checked after breakfast, right before going to the beauty shop.	F 282	hygiene, repositioning and toileting at time of admission. Care plan will be developed t oaddress individual hygiene, toileting and positioning needs. Other residents care plan will be reviewed quarterly and with significant change in condition. Nurses and nursing assistants will be educated on following individual plan of care for repositioning, personal hygiene and toileting. Weekly audits of repositioning, personal hygiene and toileting will be completed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Date of completion: 3/22/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 282	Continued From page 2	F 282		

R65's plan of care regarding toileting was not followed.

R65's care plan revised on 12/29/15, directed staff R65 had frequent incontinence of bladder. Interventions for toileting directed staff to toilet R65 every 2 hours and check for incontinence, provide thorough skin care after incontinent episodes and apply barrier cream as needed.

R65's activities of daily living assessment dated 9/12/15, indicated R65 was occasionally incontinent, was on a scheduled toileting plan, and utilized liners/briefs. A nursing assistant's undated care sheet indicated R65 required assist of one person and directed to toilet every two hours and check for incontinence.

On 2/10/16, at 7:25 a.m,. R65 was observed lying in bed wearing an incontinent brief. Nursing assistant (NA)-A was in room and getting ready to do cares. During the cares, R65 was observed to be wet and incontinent brief was changed during the cares. After NA-A completed the cares, R65 was ambulated to the weighing scale, weighed and then wheeled to the dining room at approximately 7:50 a.m.

-At 8:30 a.m. R65 wheeled out of the dining room heading towards own room.
-At 8:35 a.m. NA-A entered R65's room and assisted R65 to bed. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. R65 was continuously observed to be lying in bed until 10:38 a.m. At 10:38 a.m. NA-B was observed entering R65's room, offered R65 water and then left the room. R65 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 3	F 282		

offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed.

NA-A was interviewed at 11:07 a.m. Stated that R65 needed help with transfers and toileting and is incontinent of urine. NA-A verified R65 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since he was assisted out of bed over three hours prior. NA-A confirmed R65 was not provided toileting assistance from 7:25 a.m. until 11:07 a.m. NA-A explained that, "we are supposed to toilet him every two hours but I assumed the other girl (referring to NA-B) will because I'm helping her." NA-A explained that she was "just heading to his room to help him."

R65 was interviewed at 11:19 a.m., R65 confirmed that he was wet and no one had offered to toilet him or change his brief. R65 stated "They only change me when they get me up for meals."

At 11:26 a.m., NA-A was observed providing incontinent care to R65. R65's incontinent brief was heavily saturated with urine.

NA-B was interviewed at 11:28 a.m. explained that R65 is usually incontinent. NA-B verified that she had not toileted R65 either.

Registered nurse (RN)-A was interviewed on 2/10/16, at 2:06 p.m. explained that if a care plan directs to check and toilet every two hours, her expectations was nursing staff was doing so. RN-A stated "I expect the nursing staff to check and take him to the bathroom every two hours."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 282	Continued From page 4 On 2/11/16, at 9:09 a.m. director of nursing (DON) was interviewed. Confirmed R65's care plan directed staff to assist to toilet every two hours and check for incontinence. DON stated "My expectation is that they should follow the care plan and do as it says. If resident is supposed to be toileted every two hours, I expected staff to have done that." The facility failed to follow R37's care plan for activities of daily living (ADLs) Review of R37's care plan, revised 2/2006, directed staff that R37 required assist of one with ADLs Nursing assistant assignment sheet undated, reads, "ADL's A-1 (assist of one)." On 2/08/16 at 6:00 p.m., during an attempt to interview R37, she was observed to have several gray/white facial hairs to the upper lip and the chin area. On 2/9/16 9:25 a.m., R37 was observed in a wheelchair in own room and had several white grayish facial hairs to the upper lip and the chin area. On 2/10/16 8:33 a.m., R37 was observed in room sitting in wheelchair and was observed to still have numerous facial hairs. On 2/10/16 at 8:43 a.m., registered nurse (RN)-A verified R37 was unshaven and indicated the expectation was that the resident was supposed to be shaven as needed per the care plan. In addition, RN-A stated, shaving is part of ADL care plan.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 5 On 2/10/16 at 8:49 a.m., RN-B acknowledged R37 was unshaven and indicated the expectation was that the resident was supposed to be shaved as needed. On 2/10/16 at 9:15 a.m., the director of nursing indicated the expectation was residents should be shaved as needed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal hygiene care for 1 of 1 residents (R37) who required extensive assistance of staff for personal cares. Findings include: R37 was admitted to the facility with diagnosis that included muscle weakness, developmental delay and dysphagia. R37's quarterly Minimum Data Set (MDS) dated 11/17/15, identified R37 required extensive assist with bed mobility, transfers, dressing, eating, toileting and personal hygiene needs. Nursing assistant assignment sheet undated, reads, "ADL's (activities of daily livings) A-1	F 311	Resident #37 is receiving personal care hygiene that includes shaving of facial hair as outlined in individual care plan. New admissions/re-admits will be assessed for personal care hygiene needs. Individual care plans will be developed for personal hygiene needs Other residents will continue to recieve personal hygiene as outlined in individual care plans. Care plans will be reviewed quarterly and with any change in condition Nurses and nursing assistants will be re-educated on providing personal care hygiene as outlined in resident plan of care.	3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 6 (assist of one)". The care plan revision goal dated 2/2016, identified R37 had "Physical functioning deficit related to: Self care impairment related to advanced dementia secondary to MR (mental retardation). I will maintain my current level of function. ADLS: assist x 1, A-2 (assist of two) PRN (as needed) with bed mobility, toileting and bathing". On 2/08/16 at 6:00 p.m., during an attempt to interview R37, several gray/white facial hairs to the upper lip and the chin area were observed. On 2/9/16 9:25 a.m., R37 was observed to be sitting in a wheelchair in own room and several white grayish facial hairs to the upper lip and the chin area were noted. On 2/10/16 8:33 a.m. R37 was observed to still have numerous facial hairs. On 2/10/16 at 8:43 a.m. registered nurse (RN)-A verified R37 was unshaven and indicated the expectation was that residents were supposed to be shaved as needed per care plan. In addition, RN-A stated, shaving is part of ADL care plan. On 2/10/16 at 8:49 a.m., RN-B acknowledged R37 was unshaven and indicated the expectation was that residents were supposed to be shaved as needed. On 2/10/16 at 9:15 a.m. director of nursing commented that the expectation was that residents are shaved as needed. Policy and procedure titled SHAVING THE	F 311	Weekly audit of resident personal care hygiene will be completed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Date of compliance: 3/22/2016	

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	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 311	Continued From page 7 RESIDENT, dated 2006, indicated, "To remove facial hair and improve the resident's appearance and morale."	F 311		
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 necessary care and services for urinary incontinence for 1 of 1 resident (R10) who was dependent on staff for toileting. Findings include: Review of R10's quarterly minimum data set (MDS) dated 1/5/16 indicated R10 was frequently incontinent of urine and required extensive assistance with toileting with one person physical assist. The care area assessment (CAA) from the annual MDS dated 4/23/15, indicated R10 was incontinent of bowel and bladder, and required staff assist with incontinence cares "by checking resident every two hours and change PRN (as needed)". Review of R10's plan of care revised on 1/18/16 indicated the following: "Alteration in elimination of bowel and bladder Functional and mixed bowel and urinary incontinence, dependence in	F 312	Resident #10 is checked and changed per individual plan of care for incontinence. Other residents will continue to receive toileting services as outlined in individual care plan. New admissions/re-admissions will be assessed for toileting/incontinence needs. Individual care plans will be developed for toileting/incontinence as needed. Nurses and nursing assistants will be re-educated on providing toileting/incontinence needs as outlined in resident plan of care. Weekly audit of toileting/incotinence services will be completed. DNS or designee will be responsible for ocmpliance.	3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 312	Continued From page 8 ADL's (activities of daily living). Resident is frquently (sic) to always incontinent of bowel and bladder." Interventions included "Check Q (every) 2 hours and change PRN (as needed)". "toileting assist: Total assist of 1 staff member." On 2/10/16 at 9:00 a.m., R10 was sitting in room in wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At 11:33 a.m., the Director of Nursing (DON) brought R10 back to room and explained that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA) -C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred onto the bed, NA-C removed the saturated incontinence brief, and applied a new brief. Interview with NA-C at 11:47 a.m., revealed R10 was "check and change every two hours and required repositioning every two hours". NA-C indicated R10 was checked after breakfast, right before going to the beauty shop and not checked again until now, (2 hours 40 minutes later).	F 312	QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Date of compliance: 3/22/2016	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 314	Continued From page 9 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 services to prevent skin breakdown for 1 of 1 resident (R10) who was at risk for skin breakdown and had a history of skin breakdown. Findings include: Review of R10's quarterly minimum data set (MDS) dated 1/5/16, indicated R10 received extensive assistance with bed mobility, transfers and did not ambulate. The MDS identified R10 at risk for developing pressure ulcers and had interventions of a pressure reducing device for bed and chair. R10's care area assessment (CAA) dated 4/23/15 indicated R10's risk factors included needing assist with mobility, incontinence, at risk for friction and sheer, decreased activity and being chair bound. Review of R10's plan of care revised on 1/18/16 indicated the following: "at risk for alteration in skin integrity, had a history of skin damage to coccyx and buttocks, and required repositioning every two hours, with assist of 1 - 2 staff." On 2/10/16 at 9:00 a.m., R10 was sitting in room in a wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At	F 314	Resident #10 is repositioned as outlined in individual plan of care. New admissions and re-admissions will be assessed for positioning needs. Individual care plan will be developed to address positioning. Other residents will continue to receive positioning needs as outlined in individual care plan. Care plans will be reviewed quarterly and will significant change in condition. Nurses and nursing assistants will be educated on providing positioning needs as care planned. Weekly audits of positioning needs will be completed. DNS or designee is responsible person. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Completion date: 3/22/2016	

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F 314	Continued From page 10 11:33 a.m., the Director of Nursing (DON) brought R10 back to room. The DON indicated that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA) -C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred and repositioned onto the bed. Interview with NA-C at 11:47 a.m., revealed R10 required repositioning every two hours and that R10 had been repositioned after breakfast, right before going to the beauty shop.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 resident (R65) in the sample, who was identified as incontinent of urine, received the necessary care and services to manage incontinence. Findings include:	F 315	Resident #65 is receiving toileting services as outlined in individual plan of care. New admissions/re-admissions will continue to be assessed for toileting needs. Individal care plan developed to address toileting. Other residents are	3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 315	Continued From page 11 R65's quarterly Minimum Data Set (MDS) dated 12/16/15, indicated R65 was cognitively intact, required extensive assistance of one person with bed mobility, transferring, dressing and toileting, and was always incontinent of urine. R65's prior admission MDS dated 9/12/15, indicated R65 was frequently incontinent with urine. R65's corresponding Care Area Assessment (CAA) dated 9/19/15, indicated R65 was frequently incontinent of urine, received extensive assistance with toileting, changing and pericare after incontinent episodes. R65's CAA directed staff to see care plan for goals and interventions. R65's care plan revised on 12/29/15, identified R65 to have frequent incontinence of bladder and required extensive assist with changing and pericare after incontinence. Interventions included; assist to toilet every 2 hours and check for incontinence, provide thorough skin care after incontinent episodes and apply barrier cream as needed. R65's activities of daily living assessment dated 9/12/15, indicated R65 was occasionally incontinent, was on a scheduled toileting plan, and utilized liners/briefs. A nursing assistant's undated care sheet indicated R65 required assist of 1 person and directed to toilet every two hours and check for incontinence. On 2/10/16, at 7:25 a.m. R65 was observed lying in bed wearing an incontinent brief. Nursing assistant (NA)-A was in room and getting ready to do cares. During the cares, R65 was observed to be wet and incontinent brief was changed during the cares. After NA-A completed the cares, R65 was ambulated to the weighing scale, weighed and then wheeled to the dining room at	F 315	receiving toileting assistance as outlined in individual care plan. Care plan is reviewed quarterly and wit hany change in condition. Nurses and nursing assistants will be re-educated on following individual plan of care for toileting. Weekly audits of toileting services will be completed. DNS or designee is responsible party. QAA will provide redirection or change when necessary and dictate continuatio nor completion of this monitoring process based on compliance date. Completion date: 3/22/2016	

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F 315	Continued From page 12	F 315		

approximately 7:50 a.m.

-At 8:30 a.m. R65 wheeled out of the dining room heading towards own room.
-At 8:35 a.m. NA-A entered R65's room and assisted R65 to bed. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. R65 was continuously observed to be lying in bed until 10:38 a.m. At 10:38 a.m. NA-B was observed entering R65's room, offered R65 water and then left the room. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed.

NA-A was interviewed at 11:07 a.m. Stated that R65 needed help with transfers and toileting and is incontinent of urine. NA-A verified R65 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since being assisted out of bed over three hours prior. NA-A confirmed R65 was not provided toileting assistance from 7:25 a.m. until 11:07 a.m. NA-A explained that, "we are supposed to toilet him every 2 hrs but I assumed the other girl (referring to NA-B) will because I'm helping her." NA-A explained that she was "just heading to his room to help him."

R65 was interviewed at 11:19 a.m. R65 confirmed that he was wet and no one had offered to toilet him or change his brief. R65 stated "They only change me when they get me up for meals."

At 11:26 a.m. NA-A was observed providing incontinent care to R65. R65's incontinent brief was heavily saturated with urine.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 13 NA-B was interviewed at 11:28 a.m. explained that R65 is usually incontinent. NA-B verified that she had not toileted R65 either. Registered nurse (RN)-A was interviewed on 2/10/16, at 2:06 p.m. explained that if a care plan directs to check and toilet every two hours, her expectations were that nursing staff was doing so. RN-A stated "I expect the nursing staff to check and take him to the bathroom every two hours." On 2/11/16, at 9:09 a.m. director of nursing (DON) was interviewed. Confirmed R65's care plan directed staff to assist to toilet every two hours and check for incontinence. DON stated "My expectation is that they should follow the care plan and do as it says. If resident is supposed to be toileted every two hours, I expected staff to have done that." A facility's Incontinence Management/Bladder Function Guideline dated 6/9/15, identified the purpose as "Manage urinary incontinence, restore or maintain as much normal bladder function as possible...restore the resident's dignity." The policy directed staff to "Develop a schedule of toileting times specific to the resident...Observe and record the resident's voiding pattern and revise the toileting schedule to meet the resident's toileting needs."	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 332	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered without error for 2 of 7 residents (R77, R11) whose medication administration was observed. This resulted in a medication error rate of 12%. Findings include: R77's signed physician orders dated 11/12/15, indicated R77 had an order for Insulin Aspart Solution, inject 5 units subcutaneously before meals. On 2/10/16, at 8:06 a.m., licensed practical nurse (LPN)-B was observed to wash hands, obtained insulin FlexPen from medication cart, took the cap off, cleansed rubber seal, applied needle, and dialed up 5 units of insulin. LPN-B gathered clean glucometer, alcohol wipes, cotton balls, Flexpen and entered room where R77 was seated on bed. LPN-B washed hands, applied clean gloves, cleansed R77's abdomen and was ready to inject insulin. LPN-B was not observed to prime Flexpen first before dialing up required insulin dose. When asked LPN-B if she had primed Flexpen, stated no, she forgot to prime insulin pen with 2 units first. R11's signed physicians orders dated 10/13/15, indicated R11 had an order for Insulin Aspart Solution 100 unit/ml inject 2 unit subcutaneously one time a day for DM-2 (Diabetes Mellitus type 2) with breakfast, Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine)(long acting insulin) inject 10 units subcutaneously in	F 332	Resident #77 and 11 are receiving insulin as ordered. Insulin flex pens are primed and 2 units discarded first before dialing up ordered dose of insulin. New admissions/re-admissions with orders for insulin via insulin pen will receive injection that includes priming of pen and discarding 2 units prior to drawing up and administering ordered dose of insulin. Other residents with orders for insulin administration via flex pen will have flex pen primed with 2 units discarded first before dialing up ordered insulin dose. nurses have been re-educated on administration of insulin via flex pen. Weekly audits of insulin administration via flex pen will be completed. DNS or designee will be responsible party for compliance. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Compliance date: 3/22/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 332	Continued From page 15	F 332		

the morning for DM-2, hold for blood sugar less than 70, Novolog FlexPen Solution Pen-Injector 100 unit/ml (Insulin Aspart) inject as per sliding scale.

The Medication Administration Record (MAR) dated 2/11/15, indicated: Lantus solution 100 unit/ml (Insulin Glargine) inject 12 unit subcutaneously two times a day for DM, Novolog FlexPen solution pen-injector 100 unit/ml (insulin Aspart) inject 5 units subcutaneously with meals for DM, hold if BS (blood sugar) less than 120, and Novolog FlexPen solution pen-injector 100 unit/ml (Insulin Aspart) inject as per sliding scale, 201-250=3 units, subcutaneously with meals for DM. Blood glucose reading was 204.

On 2/10/16, at 8:29 a.m., LPN-A was observed to wash hands, obtained Novolog Flexpen from medication cart, took the cap off, cleansed rubber seal, applied needle, dialed up 5 units of insulin scheduled with meals and 3 units of insulin per sliding scale for a total of 8 units. LPN-A obtained Lantus SoloStar Flexpen from medication cart, took the cap off, cleansed rubber seal, applied needle, dialed up 12 units of insulin scheduled two times a day. LPN-A gathered clean glucometer, alcohol wipes, cotton balls, Flexpens and entered room where R11 was seated in her wheelchair. LPN-A washed hands, applied clean gloves, and cleansed R11's abdomen. LPN-A was not observed to prime Flexpens first before dialing up required insulin doses. When asked, LPN-A if she had primed Flexpens first before dialing insulin doses, LPN-A stated was not aware she should prime Flexpens first. LPN-A removed gloves, left room, discarded needles in sharps container, alcohol wiped Flexpens, applied new needles and primed Flexpens. LPN-A entered

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	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 332	Continued From page 16	F 332		

room, washed hands, applied gloves, alcohol wiped R11's abdomen and injected insulin.

On 2/10/16, at 8:41 a.m. LPN-A stated she just remembered there was an in-service on how to prime insulin pens and stated she should have primed the pens first.

On 2/10/16, at 12:00 noon when interviewed, director of nursing (DON) stated she expected nurses to prime insulin pens first before drawing up insulin for injections.

On 2/11/16, at 12:24 p.m. consultant pharmacist (CP) stated nurses should always prime insulin pens first so residents obtain correct insulin amounts.

A facility insulin policy was requested but none provided.

Facility provided Novolog FlexPen Instructions/Using the Novolog Insulin Pen dated 2/10/16, which directed staff to:
"Step 2: Doing the airshot before each injection Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing:
-Turn the dose selector to 2 units
-Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top
-Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle
-If no drop appears, change the needle and repeat. If you still do not see a drop of insulin after 6 tries, do not use the FlexPen and contact Novo Nordisk at 1-800-727-6500. A small air

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	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 332	Continued From page 17 bubble may remain at the needle tip, but it will not be injected"	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 441	Continued From page 18 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were implemented during resident care for 1 of 3 residents (R65) observed during personal care. Findings include: On 2/10/16, from 7:25 a.m. to 7:50 a.m. continual observation of personal cares for R65 was conducted. R65 was lying in bed, with Nursing assistant (NA)-A at bedside and wore disposable gloves on both hands. NA-A had two wet wash cloths set-up on a plastic bag on top of R65's bed. NA-A washed R65's arms, underarm and abdominal area. NA-A removed R65's incontinent brief, which was observed to be heavily saturated with urine. NA-A placed the soiled brief in the garbage bag. Without changing gloves, NA-A asked R65 to turn to the wall and proceeded to wash R65's back and performed perineal cares using the same wash cloth. After NA-A cleansed R65's bottom, with the same soiled gloves, NA-A opened a top drawer of R65's bedside stand, dug into the bottom of the drawer and pulled out a Durable barrier cream (Cavilon), squeezed the cream onto her hands (with dirty gloves on) and applied the cream to R65's back. With the same dirty gloves, NA-A returned the cream tube to R65's bedside dresser. With the same dirty gloves, NA-A grabbed a clean dry brief that was sitting on R65's wheelchair (w/c) and put it on resident. NA-A then grabbed R65's pants and	F 441	Resident #65 is receiving personal care assistance following infection control guideline for hand washing. Hands are washed before beginning personal cares and upon completion of cares. Gloves are changed and hands are washed upon removal of incontinence brief, peri-care, dirty to clean and whenever gloves are removed. Other residents will continue to receive assistance with personal cares per infection control guideline for handwashing. Nurses and nursing assistants and all staff providing care delivery will be re-educated on handwashing. Weekly audits will be completed for handwashing with care delivery. DNS or designee is responsible party. QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Compliance date: 3/22/2016	

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	245201	A. BUILDING _____ B. WING _____	02/11/2016

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F 441	Continued From page 19	F 441		

shirt from w/c and dressed R65 using same dirty gloves. Using the same dirty gloves, NA-A opened R65's bedside dresser drawers one after the other and stated that she was looking for R65's socks. NA-A then opened R65's closet with same dirty gloves and proceeded to search for socks, touching and moving R65's clothing around. NA-A grabbed R65's shoes that were sitting on w/c, held the bottom of shoes and helped R65 to put them on. With same gloves, NA-A opened R65's top drawer, pulled out a comb and combed R65's hair, touching R65's hair and head. NA-A again opened the drawer using same gloves, put the comb back, pulled out an emesis basin from the drawer that contained R65's toothpaste and toothbrush and proceeded to ambulate R65 to the bathroom. NA-A set-up the toothbrush and gave it to R65 to brush teeth. NA-A then removed both gloves and washed her hands.

At 8:06 a.m. NA-A was interviewed. Verified that she never changed gloves nor washed hands during the entire personal care process. NA-A explained that she is supposed to wash hands before and after wearing gloves, when the gloves get dirty and before touching clean surfaces. NA-A stated "I totally forgot. I know I wasn't supposed to be touching stuff with dirty gloves. I guess I got nervous." NA-A confirmed that she had received infection control training and is supposed to adhere to it.

R65's quarterly Minimum Data Set (MDS) dated 12/16/15, indicated R65 was cognitively intact, required extensive assistance of one person with bed mobility, transferring, dressing and toileting, and was always incontinent of urine. R65's prior admission MDS dated 9/12/15, indicated R65

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F 441	Continued From page 20 was frequently incontinent with urine. R65's corresponding Care Area Assessment (CAA) dated 9/19/15, indicated R65 was frequently incontinent of urine, received extensive assistance with toileting, changing and pericare after incontinent episodes. On 2/11/16, at 10:41 a.m. director of nursing (DON) was interviewed. Explained that staff have been trained about infection control. DON stated her expectations was that all staff follow the infection control policies. DON stated that at a minimum, she expected the NA-A to have changed gloves and washed hands when "moving from dirty to clean." A facility's Handwashing/Hand hygiene policy dated 8/14, directed that "All personal shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personal, residents, and visitors.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 9, 2016. At the time of this survey, Golden Living Center Lynwood Building 01 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 1-story building was determined to be of Type II (111) construction. Original year of construction was 1962 with an addition in 1990, both buildings are of the same type of construction and 1-story. It has a partial basement. The building interior is protected by automatic fire sprinklers. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. All resident sleeping rooms have smoke detection. The facility has a capacity of 54 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.

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	245201	A. BUILDING **02 - BUILDING 2** B. WING _____	**02/09/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Divison on February 9, 2016. At the time of this survey, Golden Livingcenter Lynwood Building 02 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) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. In 2007, a 1 story addition to the 1990 building West was constructed and was determined to be of type II(111) construction. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in each resident room that is monitored for fire department notification. The facility has a capacity of 54 with a census was 54 at the time of this survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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

REVISED LETTER

Electronically submitted
March 15, 2016

Ms. Lynn Hogendorn, Administrator
Golden LivingCenter - Lynwood
5700 East River Road
Fridley, MN 55432

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5201025 and Complaint Number H5201049

Dear Ms. Hogendorn:

The above facility was surveyed on February 8, 2016 through February 11, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5201049 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Susanne Reuss, Unit Supervisor, at (651) 201-3793.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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
	00935	A. BUILDING: _____ B. WING _____	02/11/2016

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GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 February 8th, 9th, 10th, and 11th, 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. A complaint investigation was conducted to investigate complaint H5201049. No correction orders are issued. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	02/11/2016

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		3/22/16

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in a written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. This had the potential to affect all 41 residents residing in the facility and resident representatives/families. Findings Include: On 2/11/16, at 11:43 a.m., the administrator confirmed the facility did not have any consumer education or information related to dementia / Alzheimer's training . The administrator provided the "Golden Living Centers Welcome to Our Living Center Center" booklet dated 2012. She stated that a copy of the booklet was supposed to be posted in the hallway by the business cards and was to be given to all new residents on admission. The administrator confirmed there was no information on dementia/Alzheimer's training, categories of staff trained, frequency and topics covered in the training, in the booklet. SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide the information describing the staff training program, categories of employees trained and the frequency of the training, as required. The administrator or designee could develop an auditing system to ensure compliance.	2 302	Corrected	

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2 302	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 302		
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 ensure the plan of care was followed regarding toileting for 2 of 2 residents (R10, R65) observed for incontinence care, 1 of 2 residents (R10) observed for repositioning and 1 of 2 residents (R37) observed for activities of daily living (ADL's) Review of R10's plan of care revised on 1/18/2016 indicated the following: "Alteration in elimination of bowel and bladder Functional and mixed bowel and urinary incontinence, dependence in ADL's (activities of daily living). Resident is frquently (sic) to always incontinent of bowel and bladder." Interventions included "Check Q (every) 2 hours and change PRN (as needed)". "toileting assist: Total assist of 1 staff member." The plan of care also directed staff that R10 was at risk for alteration in skin integrity, had a history of skin damage to coccyx and buttocks, and required repositioning every two hours, with assist of 1 - 2 staff.	2 565	Corrected	3/22/16

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2 565	Continued From page 5 On 2/10/16 at 9:00 a.m., R10 was sitting in her room in a wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At 11:33 a.m., the Director of Nursing (DON) brought R10 to room. The DON indicated that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA)-C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred onto the bed, NA-C removed the saturated incontinence brief, and applied a new brief. Interview with NA-C at 11:47 a.m., revealed R10 was "check and change every two hours and required repositioning every two hours". NA-C indicated R10 was checked after breakfast, right before going to the beauty shop. R65's plan of care regarding toileting was not followed. R65's care plan revised on 12/29/15, directed staff R65 had frequent incontinence of bladder. Interventions for toileting directed staff to toilet R65 every 2 hours and check for incontinence, provide thorough skin care after incontinent episodes and apply barrier cream as needed. R65's activities of daily living assessment dated 9/12/15, indicated R65 was occasionally incontinent, was on a scheduled toileting plan, and utilized liners/briefs. A nursing assistant's undated care sheet indicated R65 required assist	2 565		

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2 565	Continued From page 6 of one person and directed to toilet every two hours and check for incontinence. On 2/10/16, at 7:25 a.m,. R65 was observed lying in bed wearing an incontinent brief. Nursing assistant (NA)-A was in room and getting ready to do cares. During the cares, R65 was observed to be wet and incontinent brief was changed during the cares. After NA-A completed the cares, R65 was ambulated to the weighing scale, weighed and then wheeled to the dining room at approximately 7:50 a.m. -At 8:30 a.m. R65 wheeled out of the dining room heading towards own room. -At 8:35 a.m. NA-A entered R65's room and assisted R65 to bed. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. R65 was continuously observed to be lying in bed until 10:38 a.m. At 10:38 a.m. NA-B was observed entering R65's room, offered R65 water and then left the room. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. NA-A was interviewed at 11:07 a.m. Stated that R65 needed help with transfers and toileting and is incontinent of urine. NA-A verified R65 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since he was assisted out of bed over three hours prior. NA-A confirmed R65 was not provided toileting assistance from 7:25 a.m. until 11:07 a.m. NA-A explained that, "we are supposed to toilet him every two hours but I assumed the other girl (referring to NA-B) will because I'm helping her." NA-A explained that she was "just heading to his room to help him."	2 565		

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2 565	Continued From page 7 R65 was interviewed at 11:19 a.m., R65 confirmed that he was wet and no one had offered to toilet him or change his brief. R65 stated "They only change me when they get me up for meals." At 11:26 a.m., NA-A was observed providing incontinent care to R65. R65's incontinent brief was heavily saturated with urine. NA-B was interviewed at 11:28 a.m. explained that R65 is usually incontinent. NA-B verified that she had not toileted R65 either. Registered nurse (RN)-A was interviewed on 2/10/16, at 2:06 p.m. explained that if a care plan directs to check and toilet every two hours, her expectations was nursing staff was doing so. RN-A stated "I expect the nursing staff to check and take him to the bathroom every two hours." On 2/11/16, at 9:09 a.m. director of nursing (DON) was interviewed. Confirmed R65's care plan directed staff to assist to toilet every two hours and check for incontinence. DON stated "My expectation is that they should follow the care plan and do as it says. If resident is supposed to be toileted every two hours, I expected staff to have done that." The facility failed to follow R37's care plan for activities of daily living (ADLs) Review of R37's care plan, revised 2/2006, directed staff that R37 required assist of one with ADLs Nursing assistant assignment sheet undated,	2 565		

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2 565	Continued From page 8 reads, "ADL's A-1 (assist of one)." On 2/08/16 at 6:00 p.m., during an attempt to interview R37, she was observed to have several gray/white facial hairs to the upper lip and the chin area. On 2/9/16 9:25 a.m., R37 was observed in a wheelchair in own room and had several white grayish facial hairs to the upper lip and the chin area. On 2/10/16 8:33 a.m., R37 was observed in room sitting in wheelchair and was observed to still have numerous facial hairs. On 2/10/16 at 8:43 a.m., registered nurse (RN)-A verified R37 was unshaven and indicated the expectation was that the resident was supposed to be shaven as needed per the care plan. In addition, RN-A stated, shaving is part of ADL care plan. On 2/10/16 at 8:49 a.m., RN-B acknowledged R37 was unshaven and indicated the expectation was that the resident was supposed to be shaved as needed. On 2/10/16 at 9:15 a.m., the director of nursing indicated the expectation was residents should be shaved as needed.	2 565		

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2 565	Continued From page 9 Based on observation, interview and document review, the facility failed to ensure the plan of care was followed regarding toileting for 2 of 2 residents (R10, R65) observed for incontinence care, 1 of 2 residents (R10) observed for repositioning and 1 of 2 residents (R37) observed for activities of daily living (ADL's) Review of R10's plan of care revised on 1/18/2016 indicated the following: "Alteration in elimination of bowel and bladder Functional and mixed bowel and urinary incontinence, dependence in ADL's (activities of daily living). Resident is frquently (sic) to always incontinent of bowel and bladder." Interventions included "Check Q (every) 2 hours and change PRN (as needed)". "toileting assist: Total assist of 1 staff member." The plan of care also directed staff that R10 was at risk for alteration in skin integrity, had a history of skin damage to coccyx and buttocks, and required repositioning every two hours, with assist of 1 - 2 staff. On 2/10/16 at 9:00 a.m., R10 was sitting in her room in a wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At 11:33 a.m., the Director of Nursing (DON) brought R10 to room. The DON indicated that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA)-C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred onto the bed, NA-C removed the saturated incontinence brief, and applied a new	2 565		

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2 565	Continued From page 10 brief. Interview with NA-C at 11:47 a.m., revealed R10 was "check and change every two hours and required repositioning every two hours". NA-C indicated R10 was checked after breakfast, right before going to the beauty shop. R65's plan of care regarding toileting was not followed. R65's care plan revised on 12/29/15, directed staff R65 had frequent incontinence of bladder. Interventions for toileting directed staff to toilet R65 every 2 hours and check for incontinence, provide thorough skin care after incontinent episodes and apply barrier cream as needed. R65's activities of daily living assessment dated 9/12/15, indicated R65 was occasionally incontinent, was on a scheduled toileting plan, and utilized liners/briefs. A nursing assistant's undated care sheet indicated R65 required assist of one person and directed to toilet every two hours and check for incontinence. On 2/10/16, at 7:25 a.m,. R65 was observed lying in bed wearing an incontinent brief. Nursing assistant (NA)-A was in room and getting ready to do cares. During the cares, R65 was observed to be wet and incontinent brief was changed during the cares. After NA-A completed the cares, R65 was ambulated to the weighing scale, weighed and then wheeled to the dining room at approximately 7:50 a.m. -At 8:30 a.m. R65 wheeled out of the dining room heading towards own room. -At 8:35 a.m. NA-A entered R65's room and	2 565		

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2 565	Continued From page 11	2 565		

assisted R65 to bed. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. R65 was continuously observed to be lying in bed until 10:38 a.m. At 10:38 a.m. NA-B was observed entering R65's room, offered R65 water and then left the room. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed.

NA-A was interviewed at 11:07 a.m. Stated that R65 needed help with transfers and toileting and is incontinent of urine. NA-A verified R65 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since he was assisted out of bed over three hours prior. NA-A confirmed R65 was not provided toileting assistance from 7:25 a.m. until 11:07 a.m. NA-A explained that, "we are supposed to toilet him every two hours but I assumed the other girl (referring to NA-B) will because I'm helping her." NA-A explained that she was "just heading to his room to help him."

R65 was interviewed at 11:19 a.m., R65 confirmed that he was wet and no one had offered to toilet him or change his brief. R65 stated "They only change me when they get me up for meals."

At 11:26 a.m., NA-A was observed providing incontinent care to R65. R65's incontinent brief was heavily saturated with urine.

NA-B was interviewed at 11:28 a.m. explained that R65 is usually incontinent. NA-B verified that she had not toileted R65 either.

Registered nurse (RN)-A was interviewed on

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2 565	Continued From page 12 2/10/16, at 2:06 p.m. explained that if a care plan directs to check and toilet every two hours, her expectations was nursing staff was doing so. RN-A stated "I expect the nursing staff to check and take him to the bathroom every two hours." On 2/11/16, at 9:09 a.m. director of nursing (DON) was interviewed. Confirmed R65's care plan directed staff to assist to toilet every two hours and check for incontinence. DON stated "My expectation is that they should follow the care plan and do as it says. If resident is supposed to be toileted every two hours, I expected staff to have done that." The facility failed to follow R37's care plan for activities of daily living (ADLs) Review of R37's care plan, revised 2/2006, directed staff that R37 required assist of one with ADLs Nursing assistant assignment sheet undated, reads, "ADL's A-1 (assist of one)." On 2/08/16 at 6:00 p.m., during an attempt to interview R37, she was observed to have several gray/white facial hairs to the upper lip and the chin area. On 2/9/16 9:25 a.m., R37 was observed in a wheelchair in own room and had several white grayish facial hairs to the upper lip and the chin area. On 2/10/16 8:33 a.m., R37 was observed in room sitting in wheelchair and was observed to still have numerous facial hairs.	2 565		

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2 565	Continued From page 13 On 2/10/16 at 8:43 a.m., registered nurse (RN)-A verified R37 was unshaven and indicated the expectation was that the resident was supposed to be shaven as needed per the care plan. In addition, RN-A stated, shaving is part of ADL care plan. On 2/10/16 at 8:49 a.m., RN-B acknowledged R37 was unshaven and indicated the expectation was that the resident was supposed to be shaved as needed. On 2/10/16 at 9:15 a.m., the director of nursing indicated the expectation was residents should be shaved as needed. 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.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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:	2 900		3/22/16

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2 900	Continued From page 14 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 services to prevent skin breakdown for 1 of 1 resident (R10) who was at risk for skin breakdown and had a history of skin breakdown. Findings include: Review of R10's quarterly minimum data set (MDS) dated 1/5/16, indicated R10 received extensive assistance with bed mobility, transfers and did not ambulate. The MDS identified R10 at risk for developing pressure ulcers and had interventions of a pressure reducing device for bed and chair. R10's care area assessment (CAA) dated 4/23/15 indicated R10's risk factors included needing assist with mobility, incontinence, at risk for friction and sheer, decreased activity and being chair bound. Review of R10's plan of care revised on 1/18/16 indicated the following: "at risk for alteration in skin integrity, had a history of skin damage to coccyx and buttocks, and required repositioning every two hours, with assist of 1 - 2 staff."	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	02/11/2016

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2 900	Continued From page 15 On 2/10/16 at 9:00 a.m., R10 was sitting in room in a wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At 11:33 a.m., the Director of Nursing (DON) brought R10 back to room. The DON indicated that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA) -C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred and repositioned onto the bed. Interview with NA-C at 11:47 a.m., revealed R10 required repositioning every two hours and that R10 had been repositioned after breakfast, right before going to the beauty shop. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing. The director of nursing or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		3/22/16

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2 910	Continued From page 16 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 resident (R65) in the sample, who was identified as incontinent of urine, received the necessary care and services to manage incontinence. Findings include: R65's quarterly Minimum Data Set (MDS) dated 12/16/15, indicated R65 was cognitively intact, required extensive assistance of one person with bed mobility, transferring, dressing and toileting, and was always incontinent of urine. R65's prior admission MDS dated 9/12/15, indicated R65 was frequently incontinent with urine. R65's corresponding Care Area Assessment (CAA) dated 9/19/15, indicated R65 was frequently incontinent of urine, received extensive assistance with toileting, changing and pericare	2 910	Corrected	

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2 910	Continued From page 17 after incontinent episodes. R65's CAA directed staff to see care plan for goals and interventions. R65's care plan revised on 12/29/15, identified R65 to have frequent incontinence of bladder and required extensive assist with changing and pericare after incontinence. Interventions included; assist to toilet every 2 hours and check for incontinence, provide thorough skin care after incontinent episodes and apply barrier cream as needed. R65's activities of daily living assessment dated 9/12/15, indicated R65 was occasionally incontinent, was on a scheduled toileting plan, and utilized liners/briefs. A nursing assistant's undated care sheet indicated R65 required assist of 1 person and directed to toilet every two hours and check for incontinence. On 2/10/16, at 7:25 a.m. R65 was observed lying in bed wearing an incontinent brief. Nursing assistant (NA)-A was in room and getting ready to do cares. During the cares, R65 was observed to be wet and incontinent brief was changed during the cares. After NA-A completed the cares, R65 was ambulated to the weighing scale, weighed and then wheeled to the dining room at approximately 7:50 a.m. -At 8:30 a.m. R65 wheeled out of the dining room heading towards own room. -At 8:35 a.m. NA-A entered R65's room and assisted R65 to bed. R65 was not offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. R65 was continuously observed to be lying in bed until 10:38 a.m. At 10:38 a.m. NA-B was observed entering R65's room, offered R65 water and then left the room. R65 was not	2 910		

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2 910	Continued From page 18 offered or prompted to use the toilet nor was R65's incontinent brief checked for incontinence or changed. NA-A was interviewed at 11:07 a.m. Stated that R65 needed help with transfers and toileting and is incontinent of urine. NA-A verified R65 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since being assisted out of bed over three hours prior. NA-A confirmed R65 was not provided toileting assistance from 7:25 a.m. until 11:07 a.m. NA-A explained that, "we are supposed to toilet him every 2 hrs but I assumed the other girl (referring to NA-B) will because I'm helping her." NA-A explained that she was "just heading to his room to help him." R65 was interviewed at 11:19 a.m. R65 confirmed that he was wet and no one had offered to toilet him or change his brief. R65 stated "They only change me when they get me up for meals." At 11:26 a.m. NA-A was observed providing incontinent care to R65. R65's incontinent brief was heavily saturated with urine. NA-B was interviewed at 11:28 a.m. explained that R65 is usually incontinent. NA-B verified that she had not toileted R65 either. Registered nurse (RN)-A was interviewed on 2/10/16, at 2:06 p.m. explained that if a care plan directs to check and toilet every two hours, her expectations were that nursing staff was doing so. RN-A stated "I expect the nursing staff to check and take him to the bathroom every two hours." On 2/11/16, at 9:09 a.m. director of nursing	2 910		

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2 910	Continued From page 19 (DON) was interviewed. Confirmed R65's care plan directed staff to assist to toilet every two hours and check for incontinence. DON stated "My expectation is that they should follow the care plan and do as it says. If resident is supposed to be toileted every two hours, I expected staff to have done that." A facility's Incontinence Management/Bladder Function Guideline dated 6/9/15, identified the purpose as "Manage urinary incontinence, restore or maintain as much normal bladder function as possible...restore the resident's dignity." The policy directed staff to "Develop a schedule of toileting times specific to the resident...Observe and record the resident's voiding pattern and revise the toileting schedule to meet the resident's toileting needs." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who receive assistance with incontinence care to assure they are receiving the necessary treatment/services to to restore as much normal bladder function as possible. The director of nursing or designee, could conduct random audits of the delivery of care, to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate	2 915		3/22/16

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2 915	Continued From page 20 treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal hygiene care for 1 of 1 residents (R37) who required extensive assistance of staff for personal cares. Findings include: R37 was admitted to this facility with diagnosis includes muscle weakness, developmental delay and dysphagia. R37's quarterly Minimum Data Set (MDS) dated 11/17/15, identified R37 required extensive assist with assist with bed mobility, transfers, dressing, eating, toileting and personal hygiene needs. R37 is severely impaired. Nursing assistant assignment sheet undated, reads, "ADL's (activities of daily livings) A-1 (assist of one)".	2 915	Corrected	

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2 915	Continued From page 21 The care plan revision goal dated 2/2016, identified R37 had "Physical functioning deficit related to: Self care impairment related to advanced dementia secondary to MR (mental retardation). I will maintain my current level of function. ADLS: assist x 1, A-2 (assist of two) PRN (as needed) with bed mobility, toileting and bathing". On 2/08/16 at 6:00 p.m., during an attempt to interview R37, she was observed to have several gray/white facial hairs to the upper lip and the chin area. On 2/9/16 9:25 a.m., R37 was observed to have several white grayish facial hairs to the upper lip and the chin area while sitting in wheelchair in her room. On 2/10/16 8:33 a.m. R37 was observed in her room sitting in her wheelchair and was observed to still have numerous facial hairs. On 2/10/16 at 8:43 a.m. registered nurse (RN)-A verified R37 was unshaven and indicated her expectation was that residents were supposed to be shaven as needed per care plan. In addition, RN-A stated, shaving is part of ADL care plan. On 2/10/16 at 8:49 a.m., RN-B acknowledged R37 was unshaven and indicated the expectation was that residents were supposed to be shaved as needed. On 2/10/16 at 9:15 a.m. director of nursing commented, her expectation was that residents would be shaved as needed. Policy and procedure titled SHAVING THE	2 915		

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2 915	Continued From page 22 RESIDENT, dated 2006, indicated, "To remove facial hair and improve the resident's appearance and morale." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review or revise policies, and provide education for staff regarding resident grooming. The Quality Assurance and Performance Improvement(QAPI) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary care and services for urinary incontinence for 1 of 1 resident (R10) who was dependent on staff for toileting. Findings include: Review of R10's quarterly minimum data set (MDS) dated 1/5/16 indicated R10 was frequently	2 920	Corrected	3/22/16

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2 920	Continued From page 23 incontinent of urine and required extensive assistance with toileting with one person physical assist. The care area assessment (CAA) from the annual MDS dated 4/23/15, indicated R10 was incontinent of bowel and bladder, and required staff assist with incontinence cares "by checking resident every two hours and change PRN (as needed)". Review of R10's plan of care revised on 1/18/16 indicated the following: "Alteration in elimination of bowel and bladder Functional and mixed bowel and urinary incontinence, dependence in ADL's (activities of daily living). Resident is frquently (sic) to always incontinent of bowel and bladder." Interventions included "Check Q (every) 2 hours and change PRN (as needed)". "toileting assist: Total assist of 1 staff member." On 2/10/16 at 9:00 a.m., R10 was sitting in room in wheelchair watching TV. At 9:23 a.m., R10 was taken to the beauty salon. At 10:15 a.m., R10 was taken from the beauty shop to the dining room where R10 attended an activity. At 11:08 a.m., R10 was moved from the dining room to the hallway, across from the nurses station. At 11:33 a.m., the Director of Nursing (DON) brought R10 back to room and explained that the nursing assistant would be "checking" R10. At 11:40 a.m., nursing assistant (NA) -C brought the Sara lift (lift used to aid in a transfer, by having the resident hold onto the lift and assist with standing) into the room. R10 was transferred onto the bed, NA-C removed the saturated incontinence brief, and applied a new brief. Interview with NA-C at 11:47 a.m., revealed R10 was "check and change every two hours and required repositioning every two hours". NA-C indicated R10 was checked after breakfast, right	2 920		

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2 920	Continued From page 24 before going to the beauty shop and not checked again until now, (2 hours 40 minutes later). SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with check and change programs. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control	21390		3/22/16

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21390	Continued From page 25 practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were implemented during resident care for 2 of 3 residents (R9, R65) observed during personal care. Findings include: R65's quarterly Minimum Data Set (MDS) dated 12/16/15, indicated R65 was cognitively intact, required extensive assistance of one person with bed mobility, transferring, dressing and toileting, and was always incontinent of urine. R65's prior admission MDS dated 9/12/15, indicated R65 was frequently incontinent with urine. R65's corresponding Care Area Assessment (CAA) dated 9/19/15, indicated R65 was frequently incontinent of urine, received extensive assistance with toileting, changing and pericare after incontinent episodes. On 2/10/16, from 7:25 a.m. to 7:50 a.m. continual observation of personal cares for R65 was conducted. R65 was lying in bed, with Nursing assistant (NA)-A at bedside and wore disposable gloves on both hands. NA-A had two wet wash cloths set-up on a plastic bag on top of R65's	21390	Corrected	

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21390	Continued From page 26 bed. NA-A washed R65's arms, underarm and abdominal area. NA-A removed R65's incontinent brief, which was observed to be heavily saturated with urine. NA-A placed the soiled brief it in the garbage bag. Without changing gloves, NA-A asked R65 to turn to the wall and proceeded to wash R65's back and performed perineal cares using the same wash cloth. After NA-A cleansed R65's bottom, with the same soiled gloves, NA-A opened a top drawer of R65's bedside stand, dug into the bottom of the drawer and pulled out a Durable barrier cream (Cavilon), squeezed the cream onto her hands (with dirty gloves on) and applied the cream to R65's back. With the same dirty gloves, NA-A returned the cream tube to R65's bedside dresser. With the same dirty gloves, NA-A grabbed a clean dry brief that was sitting on R65's wheelchair (w/c) and put it on resident. NA-A then grabbed R65's pant and shirt from w/c and dressed R65 using same dirty gloves. Using the same dirty gloves, NA-A opened R65's bedside dresser drawers one after the other and stated that she was looking for R65's socks. NA-A then opened R65's closet with same dirty gloves and proceeded to search for socks, touching and moving R65's clothing around. NA-A grabbed R65's shoes that were sitting on w/c, held the bottom of shoes and helped R65 to put them on. With same gloves, NA-A opened R65's top drawer, pulled out a comb and combed R65's hair, touching R65's hair and head. NA-A again opened the drawer using same gloves, put the comb back, pulled out an emesis basin from the drawer that contained R65's toothpaste and toothbrush and proceeded to ambulate R65 to the bathroom. NA-A set-up the toothbrush and gave it R65 to brush teeth. NA-A then removed both gloves and washed her hands.	21390		

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21390	Continued From page 27 At 8:06 a.m. NA-A was interviewed. Verified that she never changed gloves nor washed hands during the entire personal care process. NA-A explained that she is supposed to wash hands before and after wearing gloves, when the gloves get dirty and before touching clean surfaces. NA-A stated "I totally forgot. I know I wasn't supposed to be touching stuff with dirty gloves. I guess I got nervous." NA-A confirmed that she had received infection control training and is supposed to adhere to it. On 2/11/16, at 10:41 a.m. director of nursing (DON) was interviewed. explained that staff have been trained about infection control. DON stated her expectations was that all staff follow the infection control policies. DON stated that at a minimum, she expected the NA-A to have changed gloves and washed hands when "moving from dirty to clean." A facility's Handwashing/Hand hygiene policy dated 8/14, directed that "All personal shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personal, residents, and visitors. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques regarding hand hygiene are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance.	21390		

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	00935	A. BUILDING: _____ B. WING _____	02/11/2016

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21390	Continued From page 28 Time Period for Correction: Twenty one (21) days.	21390		
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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure State guidelines to ensure Employee Tuberculosis (TB) Screening, Tuberculin Skin Test (TST) and medical evaluations for 3 of 5 employees (E1, E2, E3) was completed prior to working in the facility. Findings include:	21426	Corrected	3/22/16

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21426	Continued From page 29 A review of employee files was conducted on 2/10/16, at around 1:00 p.m. The review revealed E-1 had a start date of 11/23/15. A TB symptom screen and first-step TST was done on 11/18/15 with an induration of zero (0) millimeter (mm) and interpretation reading of negative. A second TST, a blood test or a chest x-ray was not completed. E-2 had a start date of 11/12/15. A TB symptom screen and first-step TST was done on 10/29/15 with an induration of 0 mm and interpretation reading of negative. A second TST, a blood test or a chest x-ray was not completed. E-3 had a start date of 1/19/16. A TB symptom screen and first-step TST was done on 1/7/15 with an induration of 0 mm and interpretation reading of negative. A second TST, a blood test or a chest x-ray was not completed. An interview was conducted with the director of nursing (DON) on 2/11/16, at 9:15 a.m. The DON verified staff TST were not completed as per their policy. DON explained that the development staff responsible for tracking tuberculosis screening and testing for staff had quit within the last several months. The DON acknowledged that "I know we have a problem with that [staff Mantoux]." DON explained staff are supposed to have a two-step TST completed. A facility's Annual Tuberculosis (TB) Risk Assessment dated 4/15, directed, "A baseline skin testing is performed with a two-step TST for HCWs [Health Care Workers]. (Note: one test only is acceptable if there is documentation that the employee has has a negative TST within the past 12 months)." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service the staff	21426		

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21426	Continued From page 30 responsible for completing and monitoring the TB program to ensure it is consistent with current TB requirements. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		3/22/16

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21545	Continued From page 31 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered without error for 2 of 7 residents (R77, R11) whose medication administration was observed. This resulted in a medication error rate of 12%. Findings include: R77's signed physician orders dated 11/12/15, indicated R77 had an order for Insulin Aspart Solution, inject 5 units subcutaneously before meals. On 2/10/16, at 8:06 a.m., licensed practical nurse (LPN)-B was observed to wash hands, obtained insulin FlexPen from medication cart, took the cap off, cleansed rubber seal, applied needle, and dialed up 5 units of insulin. LPN-B gathered clean glucometer, alcohol wipes, cotton balls, Flexpen and entered room where R77 was	21545	Corrected	

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21545	Continued From page 32	21545		

seated on bed. LPN-B washed hands, applied clean gloves, cleansed R77's abdomen and was ready to inject insulin. LPN-B was not observed to prime Flexpen first before dialing up required insulin dose. When asked LPN-B if she had primed Flexpen, stated no, she forgot to prime insulin pen with 2 units first.

R11's signed physicians orders dated 10/13/15, indicated R11 had an order for Insulin Aspart Solution 100 unit/ml inject 2 unit subcutaneously one time a day for DM-2 (Diabetes Mellitus type 2) with breakfast, Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine)(long acting insulin) inject 10 units subcutaneously in the morning for DM-2, hold for blood sugar less than 70, Novolog FlexPen Solution Pen-Injector 100 unit/ml (Insulin Aspart) inject as per sliding scale.

The Medication Administration Record (MAR) dated 2/11/15, indicated: Lantus solution 100 unit/ml (Insulin Glargine) inject 12 unit subcutaneously two times a day for DM, Novolog FlexPen solution pen-injector 100 unit/ml (insulin Aspart) inject 5 units subcutaneously with meals for DM, hold if BS (blood sugar) less than 120, and Novolog FlexPen solution pen-injector 100 unit/ml (Insulin Aspart) inject as per sliding scale, 201-250=3 units, subcutaneously with meals for DM. Blood glucose reading was 204.

On 2/10/16, at 8:29 a.m., LPN-A was observed to wash hands, obtained Novolog Flexpen from medication cart, took the cap off, cleansed rubber seal, applied needle, dialed up 5 units of insulin scheduled with meals and 3 units of insulin per sliding scale for a total of 8 units. LPN-A obtained Lantus SoloStar Flexpen from medication cart, took the cap off, cleansed rubber seal, applied

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21545	Continued From page 33	21545		

needle, dialed up 12 units of insulin scheduled two times a day. LPN-A gathered clean glucometer, alcohol wipes, cotton balls, Flexpens and entered room where R11 was seated in her wheelchair. LPN-A washed hands, applied clean gloves, and cleansed R11's abdomen. LPN-A was not observed to prime Flexpens first before dialing up required insulin doses. When asked, LPN-A if she had primed Flexpens first before dialing insulin doses, LPN-A stated was not aware she should prime Flexpens first. LPN-A removed gloves, left room, discarded needles in sharps container, alcohol wiped Flexpens, applied new needles and primed Flexpens. LPN-A entered room, washed hands, applied gloves, alcohol wiped R11's abdomen and injected insulin.

On 2/10/16, at 8:41 a.m. LPN-A stated she just remembered there was an in-service on how to prime insulin pens and stated she should have primed the pens first.

On 2/10/16, at 12:00 noon when interviewed, director of nursing (DON) stated she expected nurses to prime insulin pens first before drawing up insulin for injections.

On 2/11/16, at 12:24 p.m. consultant pharmacist (CP) stated nurses should always prime insulin pens first so residents obtain correct insulin amounts.

A facility insulin policy was requested but none provided.

Facility provided Novolog FlexPen Instructions/Using the Novolog Insulin Pen dated 2/10/16, which directed staff to:
"Step 2: Doing the airshot before each injection Small amounts of air may collect in the cartridge

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21545	Continued From page 34 during normal use. To avoid injecting air and ensure proper dosing: -Turn the dose selector to 2 units -Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top -Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle -If no drop appears, change the needle and repeat. If you still do not see a drop of insulin after 6 tries, do not use the FlexPen and contact Novo Nordisk at 1-800-727-6500. A small air bubble may remain at the needle tip, but it will not be injected" SUGGESTED METHOD OF CORRECTION: The administrator and consultant pharmacist could review and revise policies and procedures to ensure facility was free of medication errors. The consultant pharmacist could inservice licensed staff to provide medications without error. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		