#### DEPARTMENT OF HEAL

DEPARTMENT (	OF HEALTH A	MEDICA	N SERVICES ARE/MEDICAL TO BE COMPI	_		ND TRANS	MITTAL		CAID SERVICES ID: BQDG Facility ID: 00935	
1. MEDICARE/MEDICAID PROVIDER  NO.(L1) 245201  2. STATE VENDOR OR MEDICAID NO.  (L2) 973842800  5. EFFECTIVE DATE CHANGE OF OWNERSHIP.			3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - LYNW (L4) 5700 EAST RIVER ROAD (L5) FRIDLEY, MN		(L6) <b>55432</b>		4. TYPE OF ACTIO  1. Initial  3. Termination  5. Validation  7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) <b>04/01/2006</b>			7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 8. ACCREDITATION S 0 Unaccredited 2 AOA		<b>2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDI	NG DATE: (L35)	
11. LTC PERIOD OF C From (a): To (b):  12. Total Facility Beds	ERTIFICATION	<b>54</b> (L18)	10.THE FACILITY  X A. In Complia  Program Re Compliance 1. A	nce With	AS:	2. Tecl 3. 24 H 4. 7-Da	hnical Personnel Hour RN ay RN (Rural SN	<del>-</del>	ervices Limit rector m Size	
13.Total Certified Beds		<b>54</b> (L17)		pliance with Prog and/or Applied		5. Life * Code:	Safety Code  A	9. Beds/Room (L12)		
14. LTC CERTIFIED B	ED BREAKDOWN 18/19 SNF <b>54</b>	N 19 SNF	ICF	IID		15. FACILITY 1861 (e) (1) o		(L15)		
(L37)	(L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY A	GENCY REMAR	KS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):					
17. SURVEYOR SIGN	ATURE		Date :			18. STATE SUI	RVEY AGENCY	APPROVAL	Date:	

Susanne Reuss, Unit Supervisor		(L19)	Kamala Fiske-Downing, Enforcement Specialist 03/31/2016 (L2			
P	ART II - TO BE COMP	LETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE A	AGENCY		
19. DETERMINATION OF ELIGIE  1. Facility is Eligible to	o Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ul><li>21. 1. Statement of Financial Solve</li><li>2. Ownership/Control Interest I</li><li>3. Both of the Above :</li></ul>			
2. Facility is not Eligib	(L21)					
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION <b>04/01/1975</b>	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY  05-Fail to Meet Health/Safety		
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANG A. Suspension of Admir		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change		
(L27)	B. Rescind Suspension	(L44) Date:		00-Active		
		(L45)				
28. TERMINATION DATE:	29. INTER	MEDIARY/CARRIER NO.	30. REMARKS			
	00	)454				
	(L28)	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETER	MINATION OF APPROVAL DATE	-			
	(L32)	(L33)	DETERMINATION APPROVAL			



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, Program Specialist

Kumalu Fiske Downing

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



#### 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, Program Specialist Licensing and Certification Program

Kumalu Fiske Downing

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

### POST-CERTIFICATION REVISIT REPORT

		_			
	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
	A. Building B. Wing		V0	3/25/2016	Y3
	<u> </u>		12		13
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - LY	NWOOD	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		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5
ID Prefix <u>F0</u> 483 Reg. # LSC	0282 3.20(k)(3)(ii)	Correction  Completed  03/22/2016	ID Prefix Reg. #	F0311 483.25(a)(2)	Correction  Completed  03/22/2016	ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Correction  Completed  03/22/2016
ID Prefix <u>F0</u> Reg. #  LSC	0314 3.25(c)	Correction  Completed 03/22/2016	ID Prefix Reg. #	F0315 483.25(d)	Correction  Completed 03/22/2016	ID Prefix Reg. # LSC	F0332 483.25(m)(1)	Correction  Completed 03/22/2016
ID Prefix F0 483 Reg. #	0441 3.65	Correction Completed 03/22/2016	ID Prefix Reg. #		Correction  Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction  Completed	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction  Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWED STATE AGEN  REVIEWED CMS RO  FOLLOWUP 2/11/2016	BY	REVIEWED BY (INITIALS) SR/kfd REVIEWED BY (INITIALS)					A SUMMARY OF	5/2016

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

	ARE/MEDICAID CERTIFIC - TO BE COMPLETED BY T		•			
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245201 2. STATE VENDOR OR MEDICAID NO. (L2) 973842800	3. NAME AND ADDRESS OF FAC (L3) GOLDEN LIVINGCENT (L4) 5700 EAST RIVER ROAI (L5) FRIDLEY, MN	ER - LYNW	(L6) 55432	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
<ul> <li>5. EFFECTIVE DATE CHANGE OF OWNERSHIP         (L9) 04/01/2006</li> <li>6. DATE OF SURVEY 02/11/2016 (L34)</li> </ul>	7. PROVIDER/SUPPLIER CATEGO 1 Hospital 05 HHA 02 SNF/NF/Dual 06 PRTF	09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other  8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:(L10)  0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	12/31		
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12. Total Facility Beds 13. Total Certified Beds 54 (L18)  14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  54  (L37) (L38) (L39)  16. STATE SURVEY AGENCY REMARKS (IF APPLIC	A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC  X B. Not in Compliance with Pro Requirements and/or Applied  ICF IID  (L42) (L43)  ABLE SHOW LTC CANCELLATION	ogram Waivers:	And/Or Approved Waivers Of2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director		
17. SURVEYOR SIGNATURE Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Mary Capes. HFE NE II	03/09/2016	(L19)	Kamala Fiske-Downing, Enforcement Specialist 03/14/2016 (L20			
PART II - TO BE  19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Participate 2. Facility is not Eligible  (L21)	20. COMPLIANCE WIT 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 23. LTC AGREE OF PARTICIPATION BEGINNIN 04/01/1975 (L24) (L41)		ATE	26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspensio	IVE SANCTIONS on of Admissions: (L44) duspension Date: (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active		
28. TERMINATION DATE: 2	9. INTERMEDIARY/CARRIER NO.		30. REMARKS			
(L28)	00454	(L31)				

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



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:

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

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

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

at the time of a revisit;

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

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

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

#### DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 <u>susanne.reuss@state.mn.us</u> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 03/04/2016 FORM APPROVED OMB NO. 0938-0391

AMME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LYNWOOD  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE  GOLDEN LIVINGCENTER - LYNWOOD    CALL   ID   GUMMARY STATEMENT OF DEFICIENCIES   FRIDLEY, MIN 55432    CALL   ID   GUMMARY STATEMENT OF DEFICIENCIES   FRIDLEY, MIN 55432    CALL   ID   GEACH DEFICIENCY MUST BE PRECEISED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PRIEFIX   TAG     FOOD   INITIAL COMMENTS   FOOD    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 with the regulations has been attained in accordance with your verification.    An investigation of complaint H5201049 was completed and found not to be substantiated.   An investigation of complaint H5201049 was completed and found not to be substantiated.   F 282   SS=D			245201	B. WING		02/11/2016
FREGULATORY OR LSC IDENTIFYING INFORMATION)  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 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED FRSONS/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  REGULATORY OR LOS DEPTIFYING INFORMATION)  F 000  F 000 F 000 F 000 F 000 F 000 F 000 F 282 F			NWOOD	5	700 EAST RIVER ROAD	
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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  Resident #10 is repositioned and toileted		completed and four 483.20(k)(3)(ii) SEF	nd not to be substantiated. RVICES BY QUALIFIED	F 282		3/22/16
by: Based on observation, interview and document Resident #10 is repositioned and toileted		must be provided by accordance with ea	y qualified persons in			
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).  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		by: Based on observat review, the facility fa care was followed r residents (R10, R65 care, 1 of 2 residen repositioning and 1 for activities of daily	ion, interview and document ailed to ensure the plan of egarding toileting for 2 of 2 observed for incontinence ts (R10) observed for of 2 residents (R37) observed		per individual plan of care. Resident # facial hair has been shaved and will continue to be shaved as needed per individual hygiene plan of care. Reside #65 is toileted per individual toileting p of care.	ent
continue to be assessed for personal		_			continue to be assessed for personal	(X6) DATE

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

TITLE

03/03/2016

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245201	B. WING			02/	11/2016
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LY	NWOOD		5	TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	1/18/2016 indicated elimination of bowe mixed bowel and undependence in ADL Resident is frquentl bowel and bladder. "Check Q (every) 2 needed)". "toileting member." The plan R10 was at risk for a history of skin darand required repost assist of 1 - 2 staff.  On 2/10/16 at 9:00 room in a wheelcha R10 was taken to than., R10 was taken to than., R10 was taken to the hallway, acrost 1:33 a.m., the Direct brought R10 to room the nursing assistant 1:40 a.m., nursithe Sara lift (lift use having the resident with standing) into the saturated incontine brief.  Interview with NA-C was "check and charequired repositionic required repositioni	an of care revised on a the following: "Alteration in I and bladder Functional and rinary incontinence, I's (activities of daily living). It (activities and change PRN (activities and change PRN (activities assist: Total assist of 1 staff of care also directed staff that alteration in skin integrity, had mage to coccyx and buttocks, it (activities at alteration in skin integrity, had mage to coccyx and buttocks, it (activities at alteration in skin integrity, had mage to coccyx and buttocks, it (activities at alteration in skin integrity, had mage very two hours. At a total activity. At a moved from the dining room assistant (NA)-C brought daily assistant (NA)-C brought daily assistant (NA)-C brought daily assistant (NA)-C brought daily assistant (NA)-C removed the noce brief, and applied a new and ang every two hours. NA-C checked after breakfast, right	F 2	282	hygiene, repositioning and toileting of admission. Care plan will be dev t oaddress individual hygiene, toilet positioning needs.  Other residents care plan will be requarterly and with significant change condition.  Nurses and nursing assistants will educated on following individual placare for repositioning, personal hygiand toileting.  Weekly audits of repositioning, pershygiene and toileting will be completed by the party.  QAA will provide redirection or change when necessary and dictate continuor completion of this monitoring probased on compliance date.  Date of completion: 3/22/2016	eloped ing and viewed ge in be an of giene sonal eted.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	E SURVEY PLETED
		245201	B. WING			02/ <sup>-</sup>	11/2016
	PROVIDER OR SUPPLIER	NWOOD		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 2	F 2	282			
	R65's plan of care if ollowed.	regarding toileting was not					
	staff R65 had frequ Interventions for toi R65 every 2 hours provide thorough sk	ent incontinence of bladder. leting directed staff to toilet and check for incontinence, kin care after incontinent barrier cream as needed.					
	9/12/15, indicated F incontinent, was on and utilized liners/b undated care sheet	laily living assessment dated R65 was occasionally a scheduled toileting plan, riefs. A nursing assistant's indicated R65 required assist directed to toilet every two r incontinence.					
	in bed wearing an in assistant (NA)-A wa do cares. During th be wet and incontin the cares. After NA was ambulated to the	a.m,. R65 was observed lying nontinent brief. Nursing as in room and getting ready to e cares, R65 was observed to ent brief was changed during -A completed the cares, R65 he weighing scale, weighed to the dining room at a.m.					
	heading towards ov-At 8:35 a.m. NA-A assisted R65 to be prompted to use the incontinent brief changed. R65 was lying in bed until 10 was observed enter	wheeled out of the dining room vn room. entered R65's room and d. R65 was not offered or e toilet nor was R65's ecked for incontinence or continuously observed to be :38 a.m. At 10:38 a.m. NA-B ring R65's room, offered R65 the room. R65 was not					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245201	B. WING _		02	/11/2016
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LY	NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	R65's incontinent bor changed.  NA-A was interview R65 needed help wis incontinent of urinoffered or taken to and had not been to assisted out of bed confirmed R65 was assistance from 7:2 explained that, "we every two hours but (referring to NA-B) NA-A explained that room to help him."  R65 was interviewed confirmed that he woffered to toilet him stated "They only oup for meals."  At 11:26 a.m., NA-A incontinent care to was heavily saturated.  NA-B was interviewed that R65 is usually she had not toileted.  Registered nurse (I 2/10/16, at 2:06 p.n. directs to check and expectations was n. RN-A stated." I expectations was n. RN-A stated.	d to use the toilet nor was rief checked for incontinence red at 11:07 a.m. Stated that with transfers and toileting and he. NA-A verified R65 was not the toilet before going to bed aken to the toilet since he was over three hours prior. NA-A anot provided toileting 25 a.m. until 11:07 a.m. NA-A are supposed to toilet him to assumed the other girl will because I'm helping her." It she was "just heading to his red at 11:19 a.m., R65 was wet and no one had or change his brief. R65 hange me when they get me	F 28			

PRINTED: 03/04/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245201	B. WING		02/	11/2016
	PROVIDER OR SUPPLIER	NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 282	(DON) was interview plan directed staff hours and check for "My expectation is to plan and do as it sate to illeted every two have done that."  The facility failed to activities of daily living Review of R37's cardirected staff that RADLs  Nursing assistant as reads, "ADL's A-1 (and and and and and and and and and and	a.m. director of nursing wed. Confirmed R65's care to assist to toilet every two r incontinence. DON stated that they should follow the care tys. If resident is supposed to to hours, I expected staff to follow R37's care plan for ing (ADLs)  re plan, revised 2/2006, R37 required assist of one with ssignment sheet undated, assist of one)."  p.m., during an attempt to was observed to have several irs to the upper lip and the command had several white to the upper lip and the chin m., R37 was observed in room r and was observed to still	F 2	282		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245201	B. WING _	·····	02/11/2016
	PROVIDER OR SUPPLIER	NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 282	R37 was unshaven was that the resider as needed.  On 2/10/16 at 9:15 indicated the expect	ge 5  a.m., RN-B acknowledged and indicated the expectation it was supposed to be shaved a.m., the director of nursing tation was residents should be	F 28	32	
F 311 SS=D	IMPROVE/MAINTA A resident is given t services to maintair specified in paragra	TMENT/SERVICES TO IN ADLS  the appropriate treatment and or improve his or her abilities uph (a)(1) of this section.  IT is not met as evidenced	F3	11	3/22/16
	by: Based on observat review the facility fa hygiene care for 1 or required extensive a cares.  Findings include: R37 was admitted t that included muscl delay and dysphagi R37's quarterly Min 11/17/15, identified with bed mobility, tr toileting and person Nursing assistant a	ion, interview and document iled to provide personal of 1 residents (R37) who assistance of staff for personal of the facility with diagnosis e weakness, developmental a.  imum Data Set (MDS) dated R37 required extensive assist ansfers, dressing, eating,		Resident #37 is receiving personal or hygiene that includes shaving of facial 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 need.  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 conductated on providing personal cathygiene as outlined in resident plan of care.	al hair  ds  ve  dual  ed  dition  eare

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245201	B. WING			02/·	11/2016
_	PROVIDER OR SUPPLIER	NWOOD		57	TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD RIDLEY, MN 55432		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	identified R37 had related to: Self care advanced dementiar retardation). I will m function. ADLS: ass PRN (as needed) w bathing".  On 2/08/16 at 6:00 interview R37, sever the upper lip and th	ion goal dated 2/2016, 'Physical functioning deficit e impairment related to a secondary to MR (mental naintain my current level of sist x 1, A-2 (assist of two) with bed mobility, toileting and  p.m., during an attempt to eral gray/white facial hairs to e chin area were observed.  ., R37 was observed to be air in own room and several hairs to the upper lip and the ed.  m. R37 was observed to still ial hairs.  a.m. registered nurse (RN)-A nshaven and indicated the at residents were supposed to ed per care plan. In addition, ng is part of ADL care plan.  a.m., RN-B acknowledged and indicated the expectation were supposed to be shaved  a.m. director of nursing e expectation was that	F3	311	Weekly audit of resident personal of hygiene will be completed.  DNS or designee will be responsible party.  QAA will provide redirection or chase when necessary and dictate continuor completion of this monitoring probased on compliance date.  Date of compliance: 3/22/2016	le nge uation	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245201	B. WING			<b>02</b> /	11/2016
	PROVIDER OR SUPPLIER	NWOOD		57	TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311 F 312 SS=D	facial hair and imprand morale." 483.25(a)(3) ADL CONTROL OF The Second	2006, indicated, "To remove ove the resident's appearance ARE PROVIDED FOR		311			3/22/16
	by: Based on observat review, the facility fa care and services fo 1 resident (R10) wh toileting.  Findings include: Review of R10's qu (MDS) dated 1/5/16 incontinent of urine assistance with toile assist. The care ar the annual MDS da was incontinent of b required staff assist checking resident e PRN (as needed)".  Review of R10's pla indicated the follow of bowel and bladde	ion, interview, and document ailed to provide necessary or urinary incontinence for 1 of to was dependent on staff for arterly minimum data set indicated R10 was frequently and required extensive eting with one person physical ea assessment (CAA) from ted 4/23/15, indicated R10 powel and bladder, and it with incontinence cares "by very two hours and change and of care revised on 1/18/16 ing: "Alteration in elimination er Functional and mixed incontinence, dependence in			Resident #10 is checked and chan per individual plan of care for incontinence.  Other residents will continue to recetoileting services as outlined in individual care plan.  New admissions/re-admissions will assessed for toileting/incontinence Individual care plans will be develop toileting/incontinence as needed.  Nurses and nursing assistants will be re-educated on providing toileting/incontinence needs as outlinesident plan of care.  Weekly audit of toileting/incotinence services will be completed.  DNS or designee will be responsible ocmpliance.	eive vidual be needs. oed for oe ined in	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		(3) DATE SURVEY COMPLETED	
		245201	B. WING _	· · · · · · · · · · · · · · · · · · ·	02/	11/2016	
	PROVIDER OR SUPPLIER	NWOOD		STREET ADDRESS, CITY, STATE, ZIP O 5700 EAST RIVER ROAD FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 314 SS=D	ADL's (activities of frquently (sic) to alv bladder." Interventi (every) 2 hours and "toileting assist: Tot On 2/10/16 at 9:00 in wheelchair watch was taken to the be R10 was taken fron dining room where 11:08 a.m., R10 wato the hallway, acro 11:33 a.m., the Dire brought R10 back to nursing assistant with 1:40 a.m., nursing Sara lift (lift used to the resident hold or standing) into the roonto the bed, NA-C incontinence brief, a literview with NA-C was "check and charequired repositioni indicated R10 was before going to the again until now, (2 literature) 483.25(c) TREATM PREVENT/HEAL P	daily living). Resident is vays incontinent of bowel and ons included "Check Q I change PRN (as needed)". al assist of 1 staff member."  a.m., R10 was sitting in rooming TV. At 9:23 a.m., R10 eauty salon. At 10:15 a.m., in the beauty shop to the R10 attended an activity. At is moved from the dining room ss from the nurses station. At ector of Nursing (DON) or room and explained that the ould be "checking" R10. At assistant (NA) -C brought the aid in a transfer, by having to the lift and assist with from. R10 was transferred removed the saturated and applied a new brief.  Cat 11:47 a.m., revealed R10 ange every two hours and ng every two hours. NA-C checked after breakfast, right beauty shop and not checked nours 40 minutes later). ENT/SVCS TO	F 3	QAA will provide redirection when necessary and dictate or completion of this monite based on compliance date.  Date of compliance: 3/22/2	e continuation oring process	3/22/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245201	B. WING _		02/	11/2016	
	PROVIDER OR SUPPLIER	/NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	Continued From particles are sores recessives to promote prevent new sores.  This REQUIREME by: Based on observative, the facility of prevent skin break who was at risk for history of skin break who was at risk for history of skin break who was at risk for history of skin break who was at risk for history of skin break who was at risk for history of skin break who was at risk for history of skin break who was at risk for developing include:  Review of R10's queen with the series of a post of the series of the serie	eives necessary treatment and e healing, prevent infection and from developing.  NT is not met as evidenced tion, interview and document failed to provide services to down for 1 of 1 resident (R10) skin breakdown and had a skdown.  Larterly minimum data set 6, indicated R10 received ce with bed mobility, transfers ate. The MDS identified R10 at pressure ulcers and had pressure reducing device for 1's care area assessment 15 indicated R10's risk factors ssist with mobility, k for friction and sheer, and being chair bound. an of care revised on 1/18/16 ving: "at risk for alteration in a history of skin damage to as, and required repositioning	F 31	Resident #10 is repositioned as in individual plan of care.  New admissions and re-admiss be assessed for positioning neel Individual care plan will be devel address positioning. Other reside continue to receive positioning routlined in individual care plan.  Care plans will be reviewed qual will significant change in conditional care plans.  Nurses and nursing assistants we deducated on providing positioning as care planned.  Weekly audits of positioning need completed.  DNS or designee is responsible QAA will provide redirection or continue to redirection or continue to repositioning need to the provide redirection or continue to repositioning need to the provide redirection or continue to receive positioning need to redirection or continue to receive positioning need to redirection or continue to receive positioning need to redirection or continue to redirection or cont	ions will eds. eloped to lents will needs as erterly and on. will be ng needs eds will be person. change		
	On 2/10/16 at 9:00 in a wheelchair was was taken to the be R10 was taken fror dining room where 11:08 a.m., R10 was	a.m., R10 was sitting in room tching TV. At 9:23 a.m., R10 eauty salon. At 10:15 a.m., m the beauty shop to the R10 attended an activity. At as moved from the dining room oss from the nurses station. At		when necessary and dictate cor or completion of this monitoring based on compliance date. Completion date: 3/22/2016			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245201	B. WING		02/-	11/2016
	PROVIDER OR SUPPLIER	NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314 F 315 SS=D	11:33 a.m., the Dire brought R10 back that the nursing ass R10. At 11:40 a.m brought the Sara lif by having the resid with standing) into transferred and repulation Interview with NA-Crequired reposition R10 had been repulation B10 had been repulation R10 had been repulation B25(d) NO CATI RESTORE BLADD Based on the resident who enters indwelling catheter resident's clinical concatheterization was who is incontinent of treatment and servinfections and to refunction as possible	ector of Nursing (DON) or room. The DON indicated sistant would be "checking", nursing assistant (NA) -C t ( lift used to aid in a transfer, ent hold onto the lift and assist the room. R10 was ositioned onto the bed.  C at 11:47 a.m., revealed R10 ng every two hours and that sitioned after breakfast, right beauty shop.  HETER, PREVENT UTI, ER  ent's comprehensive cility must ensure that a sithe facility without an is not catheterized unless the pondition demonstrates that necessary; and a resident of bladder receives appropriate ites to prevent urinary tract store as much normal bladder es.	F 314			3/22/16
	by: Based on observareview, the facility f (R65) in the sample	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 2 resident e, who was identified as , received the necessary care nage incontinence.		Resident #65 is receiving toileting services as outlined in individual pl care.  New admissions/re-admissions will continue to be assessed for toileting needs. Individal care plan developed address toileting. Other residents a	l ig ed to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245201	B. WING		02/1	11/2016
	PROVIDER OR SUPPLIER	NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 315	12/16/15, indicated required extensive bed mobility, transf and was always in admission MDS da was frequently incocorresponding Cardated 9/19/15, indicincontinent of urine assistance with toil after incontinent epstaff to see care planed for incontinent epstaff to see care planed extensive pericare after incontinent episode incontinent episode needed.  R65's activities of continent, was or and utilized liners/bundated care sheer of 1 person and dirand check for incontinent episode incontinent episode needed.  On 2/10/16, at 7:25 in bed wearing an incontinent episode of 1 person and dirand check for incontinent episode incontinent episode incontinent, was or and utilized liners/bundated care sheer of 1 person and dirand check for incontinent episode.  On 2/10/16, at 7:25 in bed wearing an incontinent episode wearing an incontinent episode and check for incontinent episode.	nimum Data Set (MDS) dated I R65 was cognitively intact, assistance of one person with erring, dressing and toileting, continent of urine. R65's prior ted 9/12/15, indicated R65 ontinent with urine. R65's e Area Assessment (CAA) cated R65 was frequently e, received extensive eting, changing and pericare pisodes. R65's CAA directed an for goals and interventions. Vised on 12/29/15, identified ent incontinence of bladder and assist with changing and entinence. Interventions toilet every 2 hours and check rovide thorough skin care after es and apply barrier cream as daily living assessment dated R65 was occasionally a scheduled toileting plan, oriefs. A nursing assistant's tindicated R65 required assist ected to toilet every two hours	F 315	receiving toileting assistance as of in individual care plan.  Care plan is reviewed quarterly at hany change in condition.  Nurses and nursing assistants will re-educated on following individual care for toileting.  Weekly audits of toileting services completed.  DNS or designee is responsible pound of this monitoring based on compliance date.  Completion date: 3/22/2016	nd wit  Il be al plan of s will be earty. ange nuatio	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTIONS		(X3) DATE SURVEY COMPLETED	
		245201	B. WING			02/	11/2016
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LY	NWOOD		STREET ADDRESS 5700 EAST RIVER FRIDLEY, MN		, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	TIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 315	approximately 7:50  -At 8:30 a.m. R65 wheading towards over the sisted R65 to be prompted to use the incontinent brief changed. R65 was lying in bed until 10 was observed enterwater and then left offered or prompted R65's incontinent brief changed.  NA-A was interview R65 needed help wis incontinent of uring offered or taken to and had not been to and had not been to assisted out of bed confirmed R65 was assistance from 7:2 explained that, "we every 2 hrs but I assist to NA-B) will because explained that she was to help him."  R65 was interviewed that he was wet and him or change his because the change me when the	a.m.  wheeled out of the dining room on room. entered R65's room and d. R65 was not offered or entoilet nor was R65's ecked for incontinence or continuously observed to be as a.m. At 10:38 a.m. NA-Bring R65's room, offered R65 the room. R65 was not did to use the toilet nor was rief checked for incontinence ed at 11:07 a.m. Stated that ith transfers and toileting and the NA-A verified R65 was not the toilet before going to be daken to the toilet since being over three hours prior. NA-A not provided toileting so were three hours prior. NA-A not provided toileting so I'm helping her." NA-A was "just heading to his room did at 11:19 a.m. R65 confirmed the one had offered to toilet brief. R65 stated "They only bey get me up for meals."  was observed providing R65. R65's incontinent brief	F3	15			

STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245201	B. WING		02/	11/2016
	DER OR SUPPLIER	NWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 EAST RIVER ROAD FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC  X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
Reg 2/10 direction check hour on a check hour on a check hour on a check hour on a check hour or many plan be to have a far and revising and revising series and series and series and revising series and series and revising series and revising series and series and revising series and revision series and r	R65 is usually in had not toileted pistered nurse (F)/16, at 2:06 p.m. cts to check and ectations were to the RN-A stated "I expected and take himmers."  2/11/16, at 9:09  2/	red at 11:28 a.m. explained ncontinent. NA-B verified that I R65 either.  RN)-A was interviewed on a explained that if a care plan d toilet every two hours, her that nursing staff was doing expect the nursing staff to to the bathroom every two a.m. director of nursing wed. Confirmed R65's care to assist to toilet every two rincontinence. DON stated that they should follow the care tys. If resident is supposed to o hours, I expected staff to eurinary incontinence, restore the normal bladder function as the resident's dignity." The to "Develop a schedule of iffic to the residentObserve dent's voiding pattern and schedule to meet the needs."	F3			3/22/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3			X3) DATE SURVEY COMPLETED	
		245201	B. WING			02/	11/2016
	PROVIDER OR SUPPLIER  I LIVINGCENTER - LY	NWOOD		57	TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD RIDLEY, MN 55432	<b>3</b>	.,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	This REQUIREMENT by: Based on observatoreview, the facility for were administered residents (R77, R11 administration was medication error ratorial Findings include: R77's signed physic indicated R77 had a Solution, inject 5 ur meals.  On 2/10/16, at 8:06 (LPN)-B was obser insulin FlexPen from cap off, cleansed ruand dialed up 5 uniclean glucometer, a Flexpen and entereseated on bed. LPN clean gloves, clean ready to inject insul prime Flexpen first insulin dose. When primed Flexpen, stainsulin pen with 2 ure R11's signed physic indicated R11 had a Solution 100 unit/mone time a day for I 2) with breakfast, L	NT is not met as evidenced ion, interview and document ailed to ensure medications without error for 2 of 7 of 1) whose medication observed. This resulted in a te of 12%.  Cian orders dated 11/12/15, an order for Insulin Aspart hits subcutaneously before  a.m., licensed practical nurse wed to wash hands, obtained in medication cart, took the abber seal, applied needle, its of insulin. LPN-B gathered alcohol wipes, cotton balls, id room where R77 was N-B washed hands, applied sed R77's abdomen and was in. LPN-B was not observed to before dialing up required asked LPN-B if she had ated no, she forgot to prime	F3	32	Resident #77 and 11 are receiving as ordered. Insulin flex pens are pri and 2 units discarded first before di up ordered dose of insulin.  New admissions/re-admissions with orders for insulin via insulin pen will receive injection that includes primi pen and discarding 2 units prior to drawing up and administering order dose of insulin.  Other residents with orders for insuladministration via flex pen will have pen primed with 2 units discarded fibefore dialing up ordered insulin do nurses have been re-educated on administration of insulin via flex per Weekly audits of insulin administratiflex pen will be completed.  DNS or designee will be responsible for compliance.  QAA will provide redirection or charwhen necessary and dictate continuor completion of this monitoring probased on compliance date.  Compliance date: 3/22/2016	med aling  n ng of red  lin flex irst se.  n. tion via e party  nge uation	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245201	B. WING			02/	11/2016
	PROVIDER OR SUPPLIER	NWOOD		5700 EA	ADDRESS, CITY, STATE, ZIP CODE ST RIVER ROAD EY, MN 55432	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 332	the morning for DM than 70, Novolog F 100 unit/ml (Insulin scale.  The Medication Add dated 2/11/15, indicunit/ml (Insulin Glar subcutaneously two FlexPen solution per Aspart) inject 5 unit for DM, hold if BS (and Novolog FlexPunit/ml (Insulin Asp 201-250=3 units, stand DM. Blood glucose DM. Blood glucose On 2/10/16, at 8:29 wash hands, obtain medication cart, too seal, applied needle scheduled with measured scheduled scheduled with measured scheduled with m	l-2, hold for blood sugar less lexPen Solution Pen-Injector Aspart) inject as per sliding ministration Record (MAR) rated: Lantus solution 100 rgine) inject 12 unit of times a day for DM, Novolog en-injector 100 unit/ml (insuling subcutaneously with meals blood sugar) less than 120, en solution pen-injector 100 rart) inject as per sliding scale, ubcutaneously with meals for	F3	32			
	gloves, left room, d container, alcohol v	lexpens first. LPN-A removed iscarded needles in sharps viped Flexpens, applied new d Flexpens. LPN-A entered					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245201	B. WING		<del></del>	02/	11/2016
_	PROVIDER OR SUPPLIER			57	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RIVER ROAD RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	room, washed han wiped R11's abdor  On 2/10/16, at 8:4' remembered there prime insulin pens primed the pens fir  On 2/10/16, at 12:0 director of nursing nurses to prime insulin for inject  On 2/11/16, at 12:2 (CP) stated nurses pens first so reside amounts.  A facility insulin po provided.  Facility provided N Instructions/Using 2/10/16, which dire "Step 2: Doing the Small amounts of a during normal use ensure proper dos-Turn the dose sele-Hold your FlexPer and tap the cartride moves the air bubble -Press the push-budose selector is bashould appear at the If no drop appears repeat. If you still cafter 6 tries, do not appears the push-budose selector is bashould appear at the If no drop appears repeat. If you still cafter 6 tries, do not appears the push-budose selector is bashould appear at the If no drop appears repeat. If you still cafter 6 tries, do not appears the push-budose selector is bashould appear at the If no drop appears repeat.	ds, applied gloves, alcohol nen and injected insulin.  If a.m. LPN-A stated she just was an in-service on how to and stated she should have st.  On noon when interviewed, (DON) stated she expected sulin pens first before drawing tions.  24 p.m. consultant pharmacist should always prime insulinents obtain correct insulinents obtain correct insulinents obtain correct insulinents obtain pens first before dated but none deced staff to:  airshot before each injection air may collect in the cartridge of To avoid injecting air and ing:  ector to 2 units of with the needle pointing up, ge gently a few times, which	F	332			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245201	B. WING			<b>02</b> /	11/2016
	PROVIDER OR SUPPLIER	NWOOD		570	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST RIVER ROAD IDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332 F 441	be injected"	ge 17 at the needle tip, but it will not	F 3				3/22/16
SS=D	Infection Control Pr safe, sanitary and of to help prevent the of disease and infect (a) Infection Control The facility must es Program under white (1) Investigates, control in the facility; (2) Decides what proshould be applied to (3) Maintains a reconstruction of the facility; (b) Preventing Spression (1) When the Infect determines that a reprevent the spread isolate the resident. (c) The facility must communicable disect contact will tread in the facility must hands after each disect the facility must hand washing is incomprofessional practical (c) Linens Personnel must hand	I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections.  and of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245201	B. WING		02/11/2016	
	PROVIDER OR SUPPLIER	NWOOD	5	TREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST RIVER ROAD FRIDLEY, MN 55432	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLÉTION	
F 441	Continued From painfection.	ige 18	F 441			
	by: Based on observareview, the facility finfection control meduring resident care observed during personal per	tion, interview and document ailed to ensure appropriate easures were implemented of for 1 of 3 residents (R65) ersonal care.  25 a.m. to 7:50 a.m. continual onal cares for R65 was is lying in bed, with Nursing bedside and wore disposable ds. NA-A had two wet wash plastic bag on top of R65's R65's arms, underarm and A-A removed R65's incontinent served to be heavily saturated aced the soiled brief in the put changing gloves, NA-A to the wall and proceeded to and performed perineal cares is h cloth. After NA-A cleansed the same soiled gloves, NA-A for of R65's bedside stand, dug the drawer and pulled out a fam (Cavilon), squeezed the add (with dirty gloves on) and to R65's back. With the same deturned the cream tube to ser. With the same dirty for grabbed R65's pants and		Resident #65 is receiving personal assistance following infection contriguideline for hand washing. Hands washed before beginning personal and upon completion of cares. Gloves are changed and hands are washed upon removal of incontine brief, peri-care, dirty to clean and whenever gloves are removed.  Other residents will continue to reclassistance with personal cares per infection control guideline for handwashing.  Nurses and nursing assistants and 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 particles of this monitoring probased on compliance date.  Compliance date: 3/22/2016	eive all  r  rty.  nge uation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245201	B. WING _	·····	02	/11/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LYNWOOD				STREET ADDRESS, CITY, STATE, ZIP COI 5700 EAST RIVER ROAD FRIDLEY, MN 55432	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 441	gloves. Using the sopened R65's beds the other and state R65's socks. NA-A same dirty gloves a socks, touching an around. NA-A grab sitting on w/c, held helped R65 to put NA-A opened R65' comb and combed hair and head. NAusing same gloves an emesis basin for R65's toothpaste a to ambulate R65 to the toothbrush and	dressed R65 using same dirty same dirty gloves, NA-A side dresser drawers one after at that she was looking for then opened R65's closet with and proceeded to search for a moving R65's clothing bed R65's shoes that were the bottom of shoes and them on. With same gloves, as top drawer, pulled out a R65's hair, touching R65's A again opened the drawer applied out om the drawer that contained and toothbrush and proceeded of the bathroom. NA-A set-up I gave it to R65 to brush teeth. d both gloves and washed her	F 44	11			
	she never changed during the entire per explained that she before and after we get dirty and before NA-A stated "I total supposed to be total guess I got nervou had received infect supposed to adher R65's quarterly Mir 12/16/15, indicated required extensive bed mobility, transfand was always income."	was interviewed. Verified that d gloves nor washed hands ersonal care process. NA-A is supposed to wash hands earing gloves, when the gloves e touching clean surfaces. Illy forgot. I know I wasn't uching stuff with dirty gloves. I s." NA-A confirmed that she tion control training and is e to it.  Inimum Data Set (MDS) dated if R65 was cognitively intact, assistance of one person with ferring, dressing and toileting, continent of urine. R65's prior ated 9/12/15, indicated R65					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		245201	B. WING			02/	11/2016
	PROVIDER OR SUPPLIER	NWOOD		570	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST RIVER ROAD IDLEY, MN 55432	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	corresponding Care dated 9/19/15, indic incontinent of urine assistance with toile after incontinent ep  On 2/11/16, at 10:4 (DON) was intervie been trained about her expectations with infection control pominimum, she expectanged gloves an "moving from dirty to A facility's Handwas dated 8/14, directed trained and regular importance of hand transmission of hea All personal shall for hygiene procedures.	entinent with urine. R65's a Area Assessment (CAA) cated R65 was frequently, received extensive eting, changing and pericare isodes.  1 a.m. director of nursing wed. Explained that staff have infection control. DON stated as that all staff follow the licies. DON stated that at a ected the NA-A to have d washed hands when	F 4	41			

Printed: 02/19/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245201

B. WING

02/09/2016

NAME OF PROVIDER OR SUPPLIER

**GOLDEN LIVINGCENTER - LYNWOOD** 

STREET ADDRESS, CITY, STATE, ZIP CODE

**5700 EAST RIVER ROAD** 

OOLDLI	TEIVINGCENTER - ETNWOOD		, MN 554		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000		
K 000	FIRE SAFETY  A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Sire Marshal Division on February 9, 2010 time of this survey, Golden Living Center Lynwood Building 01 was found in substate compliance with the requirements for partin Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Association of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (Chapter 19 Existing Health Care.  This 1-story building was determined to be Type II (111) construction. Original year of construction was 1962 with an addition in	State 6. At the antial ticipation t 2000 ation LSC),	K 000		
	both buildings are of the same type of construction and 1-story. It has a partial basement. The building interior is protect automatic fire sprinklers. The facility has alarm system with smoke detection in co and spaces open to the corridors that is monitored for automatic fire department notification. All resident sleeping rooms smoke detection. The facility has a capac beds and had a census of 54 at the time survey.	s a fire rridors have city of 54			
	The requirement at 42 CFR, Subpart 483 MET.	3.70(a) is			
ABORATO	 RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEN	NTATIVE'S SIGN	IATURE	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.

F5201025

Printed: 02/19/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING 02 - BUILDING 2

(X3) DATE SURVEY COMPLETED

245201

B. WING

02/09/2016

NAME OF PROVIDER OR SUPPLIER

#### **GOLDEN LIVINGCENTER - LYNWOOD**

STREET ADDRESS, CITY, STATE, ZIP CODE

### **5700 EAST RIVER ROAD**

		FRIDLE	Y, MN 554	32	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL R OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000		
	FIRE SAFETY				
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fire Marshal Divison on February 9, 201 time of this survey, Golden Livingcenter Building 02 was found in substantial comwith the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Assoc (NFPA) Standard 101, Life Safety Code Chapter 18 New Health Care.	State 6. At the Lynwood appliance 2000 iation (LSC),			
	In 2007, a 1 story addition to the 1990 be West was constructed and was determined type II(111) construction. The building complete automatic fire sprinkler system facility has a fire alarm system that constructions and are to the corridors and in each resident roomonitored for fire department notification facility has a capacity of 54 with a censulat the time of this survey.	ned to be has a n. The sists of eas open m that is n. The			
	The requirement at 42 CFR, Subpart 48 MET.	3.70(a) is			
				**	
	*				
_ABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE	NTATIVE'S SIG	SNATURE	TITLE	(X6) DAT

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



Protecting, maintaining and improving the health of all Minnesotans

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 03/04/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING	·····	02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/03/16 **Electronically Signed** 

STATE FORM 6899 BQDG11 If continuation sheet 1 of 35

TITLE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	
A. BUILDING:	
00935 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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.	

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00935	B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - LY	NWOOD	ST RIVER RO , MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL THERE IS NO REC PLAN OF CORRECT		2 000			
2 302	or related disorder to ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.  (a) If a nursing facility Alzheimer's disease or related or segregated or generate staff and their supervisor care.  (b) Areas of require (1) an explanation or related disorders; (2) assistance with	EASE OR RELATED ING: .6503 ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	2 302			3/22/16
	written or electronic training program, th trained, the frequen topics covered.	skills. provide to consumers in form a description of the ecategories of employees acy of training, and the basic document compliance with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF				
		00935		B. WING		02/1	1/2016
	PROVIDER OR SUPPLIER	NWOOD	5700 EAS	DRESS, CITY, S T RIVER RO MN 55432	STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 302	O2 Continued From page 3			2 302			
	This MN Requirements: Based on interview facility failed to ensing a written or electron facility staff training dementia/Alzheimentraining. This had the residents residing in representatives/fames findings Include:	and documenture consumers onic form, a different for the care of r's, categories g and topics contential to an the facility and	t review, the swere provided escription of fresidents with of staff trained, overed in the affect all 41		Corrected		
	On 2/11/16, at 11:43 confirmed the facilit education or inform Alzheimer's training the "Golden Living Center Center Stated that a copy of be posted in the haland was to be given admission. The adwas no information training, categories topics covered in the SUGGESTED MET administrator or desinformation describicategories of employing frequency of the training system to end of the confirmed to the system of the confirmed to the system of the training system to end of the system of the system to end of the system to end of the system of the system to end of the system to end of the system of the system of the system to end of the system of	ry did not have ation related to ation related to The administ Centers Welcom booklet with the booklet will way by the bun to all new resministrator cornon demential of staff trained e training, in the THOD OF COF signee could ping the staff trained a ining, as requisignee could d	any consumer of dementia / strator provided ome to Our ed 2012. She was supposed to usiness cards sidents on offirmed there Alzheimer's d, frequency and the booklet.  RRECTION: The rovide the aining program, and the red. The evelop an				

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00935	B. WING		02/1	11/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	N LIVINGCENTER - LY	'NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From page 4		2 302			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-One				
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			3/22/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observati review, the facility for care was followed residents (R10, R65) care, 1 of 2 residen repositioning and 1 for activities of daily Review of R10's platified indicated elimination of bowe mixed bowel and undependence in ADL Resident is frquently bowel and bladder. "Check Q (every) 2 needed)". "toileting member." The plan R10 was at risk for a history of skin dai	ent is not met as evidenced ion, interview and document ailed to ensure the plan of regarding toileting for 2 of 2 5) observed for incontinence its (R10) observed for of 2 residents (R37) observed y living (ADL's)  an of care revised on the following: "Alteration in all and bladder Functional and rinary incontinence, L's (activities of daily living). Ily (sic) to always incontinent of a hours and change PRN (as assist: Total assist of 1 staff in of care also directed staff that alteration in skin integrity, had mage to coccyx and buttocks, itioning every two hours, with		Corrected		

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00935	B. WING		02/1	1/2016
	PROVIDER OR SUPPLIER	NWOOD 5700 EAS	DRESS, CITY, S T RIVER RO , MN 55432	STATE, ZIP CODE AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	On 2/10/16 at 9:00 room in a wheelcha R10 was taken to the a.m., R10 was taked dining room where 11:08 a.m., R10 was to the hallway, acrost 11:33 a.m., the Direst brought R10 to room the nursing assistant 11:40 a.m., nursi the Sara lift (lift use having the resident with standing) into the transferred onto the saturated incontine brief.  Interview with NA-C was "check and charequired repositioni	a.m., R10 was sitting in her air watching TV. At 9:23 a.m., ne beauty salon. At 10:15 n from the beauty shop to the R10 attended an activity. At s moved from the dining room ss from the nurses station. At actor of Nursing (DON) m. The DON indicated that not would be "checking" R10. In assistant (NA)-C brought d to aid in a transfer, by hold onto the lift and assist the room. R10 was a bed, NA-C removed the nace brief, and applied a new and ange every two hours and ng every two hours". NA-C checked after breakfast, right	2 565			
	R65's plan of care r followed.	regarding toileting was not				
	staff R65 had frequ Interventions for toi R65 every 2 hours a provide thorough sk	ent incontinence of bladder. leting directed staff to toilet and check for incontinence, kin care after incontinent barrier cream as needed.				
	9/12/15, indicated F incontinent, was on and utilized liners/b	aily living assessment dated R65 was occasionally a scheduled toileting plan, riefs. A nursing assistant's indicated R65 required assist				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00935	B. WING		02/	11/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LY	NWOOD	T RIVER RO , MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	hours and check fo On 2/10/16, at 7:25 in bed wearing an in assistant (NA)-A wa do cares. During the be wet and incontin the cares. After NA was ambulated to the and then wheeled to approximately 7:50  -At 8:30 a.m. R65 wheading towards over -At 8:35 a.m. NA-A assisted R65 to be prompted to use the incontinent brief che changed. R65 was lying in bed until 10 was observed enter water and then left offered or prompted R65's incontinent be or changed.  NA-A was interview R65 needed help w is incontinent of urin offered or taken to the and had not been to assisted out of bed	directed to toilet every two r incontinence.  a.m,. R65 was observed lying as in room and getting ready to e cares, R65 was observed to ent brief was changed during A completed the cares, R65 are weighing scale, weighed to the dining room at a.m.	2 565			
	assistance from 7:2 explained that, "we every two hours but (referring to NA-B)	not provided toileting 25 a.m. until 11:07 a.m. NA-A are supposed to toilet him I assumed the other girl will because I'm helping her." t she was "just heading to his				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 7		2 565			
	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.					
	2/10/16, at 2:06 p.n directs to check and expectations was n RN-A stated "I expe	RN)-A was interviewed on n. explained that if a care plan d toilet every two hours, her ursing staff was doing so. ect the nursing staff to check bathroom every two hours."				
	(DON) was intervie plan directed staff hours and check fo "My expectation is to plan and do as it sa	a.m. director of nursing wed. Confirmed R65's care to assist to toilet every two r incontinence. DON stated that they should follow the care ays. If resident is supposed to to hours, I expected staff to				
	The facility failed to activities of daily liv	follow R37's care plan for ing (ADLs)				
		re plan, revised 2/2006, 337 required assist of one with				
	Nursing assistant a	ssignment sheet undated.				

Minnesota Department of Health

STATE FORM BQDG11 If continuation sheet 8 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00935	B. WING		02/1	1/2016
	PROVIDER OR SUPPLIER	NWOOD 5700 EAS	DRESS, CITY, S T RIVER RO , MN 55432	STATE, ZIP CODE P <b>AD</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	reads, "ADL's A-1 (a) On 2/08/16 at 6:00 interview R37, she gray/white facial hachin area. On 2/9/16 9:25 a.m wheelchair in own r grayish facial hairs area. On 2/10/16 8:33 a.r sitting in wheelchair have numerous fac. On 2/10/16 at 8:43 verified R37 was un expectation was that to be shaven as neaddition, RN-A state plan. On 2/10/16 at 8:49 R37 was unshaven was that the resider as needed. On 2/10/16 at 9:15	p.m., during an attempt to was observed to have several irs to the upper lip and the  ., R37 was observed in a com and had several white to the upper lip and the chin  m., R37 was observed in room and was observed to still				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNWOOD			T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Based on observative review, the facility for care was followed residents (R10, R6) care, 1 of 2 resident repositioning and 1 for activities of daily.  Review of R10's platifies of daily.  Review of R10's platifies.  Review of	on, interview and document ailed to ensure the plan of regarding toileting for 2 of 2 5) observed for incontinence ts (R10) observed for of 2 residents (R37) observed validing (ADL's)  an of care revised on the following: "Alteration in and bladder Functional and rinary incontinence, and change PRN (as assist: Total assist of 1 staff of care also directed staff that alteration in skin integrity, had mage to coccyx and buttocks, itioning every two hours, with a.m., R10 was sitting in her air watching TV. At 9:23 a.m., he beauty salon. At 10:15 and from the beauty shop to the R10 attended an activity. At as moved from the dining room ses from the nurses station. At actor of Nursing (DON) m. The DON indicated that the would be "checking" R10. In gassistant (NA)-C brought d to aid in a transfer, by hold onto the lift and assist	2 565			

Minnesota Department of Health

STATE FORM BQDG11 If continuation sheet 10 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	00935	B. WING		02/	11/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - LYN	WOOD 5700 EAS	DDRESS, CITY, S' ST RIVER ROA' ', MN 55432			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
was "check and chan required repositioning indicated R10 was chefore going to the best R65's plan of care refollowed.  R65's care plan revis staff R65 had frequer Interventions for toile R65 every 2 hours ar provide thorough skir episodes and apply best R65's activities of dai 9/12/15, indicated R6 incontinent, was on a and utilized liners/brie undated care sheet in of one person and dinhours and check for incontinent (NA)-A was do cares. During the best wet and incontinent the cares. After NA-A was ambulated to the and then wheeled to approximately 7:50 a -At 8:30 a.m. R65 wheading towards own	at 11:47 a.m., revealed R10 nge every two hours and g every two hours". NA-C necked after breakfast, right eauty shop.  garding toileting was not  ged on 12/29/15, directed not incontinence of bladder. Sting directed staff to toilet not check for incontinence, in care after incontinent parrier cream as needed.  gly living assessment dated as was occasionally a scheduled toileting plan, efs. A nursing assistant's indicated R65 required assist rected to toilet every two incontinence.  a.m., R65 was observed lying continent brief. Nursing in room and getting ready to cares, R65 was observed to not brief was changed during a completed the cares, R65 e weighing scale, weighed the dining room at the care of the care o				

Minnesota Department of Health

STATE FORM BQDG11 If continuation sheet 11 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		SURVEY PLETED		
		00935		B. WING		02/-	11/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		.,
GOLDEN	I LIVINGCENTER - LY	NWOOD		T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFOI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	Continued From parassisted R65 to be prompted to use the incontinent brief chedraged. R65 was lying in bed until 10 was observed enterwater and then left offered or prompter R65's incontinent by or changed.  NA-A was interview R65 needed help was incontinent of uring offered or taken to and had not been the assisted out of bed confirmed R65 was assistance from 7:2 explained that, "we every two hours but (referring to NA-B) NA-A explained that room to help him."  R65 was interviewed confirmed that he was offered to toilet him stated "They only our for meals."  At 11:26 a.m., NA-A incontinent care to was heavily saturated. They only our for meals."	d. R65 was not offe toilet nor was R6 ecked for incontinuously obsevitable and the room. R65 was do to use the toilet orief checked for incontinuously obsevith transfers and the toilet before goaken to the toilet before goaken to the toilet sover three hours over three hours are supposed to the tassumed the otwill because I'm hat she was "just head at 11:19 a.m., For was wet and no on or change his brightness when the continent of the continent of the continent of the continent. NA-B dig R65 either.	ence or erved to be a.m. NA-B offered R65 as not nor was acontinence  Stated that colleting and R65 was not oing to bed since he was prior. NA-A eting a.m. NA-A eting a.m. NA-A eting a.m. NA-A eting a.m. has a collet him ther girl elping her." ading to his e had ef. R65 ney get me  roviding inent brief	2 565			

Minnesota Department of Health

STATE FORM BQDG11 If continuation sheet 12 of 35

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00935	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 12	2 565			
	directs to check and expectations was n RN-A stated "I expeand take him to the On 2/11/16, at 9:09 (DON) was intervie plan directed staff hours and check fo "My expectation is to plan and do as it sa	n. explained that if a care planed toilet every two hours, her ursing staff was doing so. Let the nursing staff to check bathroom every two hours."  a.m. director of nursing wed. Confirmed R65's care to assist to toilet every two r incontinence. DON stated that they should follow the care eys. If resident is supposed to o hours, I expected staff to				
	The facility failed to activities of daily liv	follow R37's care plan for ing (ADLs)				
		re plan, revised 2/2006, 37 required assist of one with				
	Nursing assistant a reads, "ADL's A-1 (	ssignment sheet undated, assist of one)."				
	interview R37, she	p.m., during an attempt to was observed to have several irs to the upper lip and the				
	wheelchair in own r	., R37 was observed in a oom and had several white to the upper lip and the chin				
		m., R37 was observed in room and was observed to still ial hairs.				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMF	SURVEY PLETED	
				A. BUILDING:			
		00935		B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD		T RIVER RO MN 55432	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 13		2 565			
	verified R37 was un expectation was that to be shaven as ne	a.m., registered nurs nshaven and indicate at the resident was si eded per the care pla ed, shaving is part of	d the upposed an. In				
	R37 was unshaven	a.m., RN-B acknowle and indicated the ex nt was supposed to b	xpectation				
		a.m., the director of ctation was residents					
	The director of nurs review and revise p to ensuring the care resident is followed designee could devand develop a mon	THOD OF CORRECT sing (DON) or design policies and procedure plan for each individe. The director of nurvelop a system to edulationing system to ensas directed by the writers.	ee could es related dual sing or icate staff ure staff				
	TIME PERIOD FOI (21) days.	R CORRECTION: Tw	enty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pr	essure	2 900			3/22/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the must coordinate the tursing care plan which	e director				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00935	B. WING	<del></del>	02/1	1/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	•		
GOLDEN	I LIVINGCENTER - LY	NWOOD	ST RIVER RC , MN 55432	PAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 14	2 900				
	without pressure sor pressure sores unle condition demonstra authenticates, that is B. a resident w receives necessary	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and ho has pressure sores y treatment and services to event infection, and prevent yeloping.					
	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.			Corrected			
	(MDS) dated 1/5/16 extensive assistance and did not ambular risk for developing printerventions of a pubed and chair. R10 (CAA) dated 4/23/1 included needing as incontinence, at risk decreased activity a Review of R10's plaindicated the follow skin integrity, had a coccyx and buttock	arterly minimum data set 5, indicated R10 received se with bed mobility, transfers te. The MDS identified R10 at pressure ulcers and had ressure reducing device for s care area assessment 5 indicated R10's risk factors sist with mobility, or for friction and sheer, and being chair bound. In of care revised on 1/18/16 ing: "at risk for alteration in history of skin damage to s, and required repositioning th assist of 1 - 2 staff."					

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	IT OF DEFICIENCIES OF CORRECTION					
			A. BOILDING.			
		00935	B. WING		02/11/	/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NWOOD	ST RIVER RO , MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	in a wheelchair wate was taken to the be R10 was taken from dining room where 11:08 a.m., R10 was to the hallway, acro 11:33 a.m., the Director of the brought R10 back to that the nursing ass R10. At 11:40 a.m. brought the Sara lift by having the reside with standing) into the transferred and repulational life in the standing in the	a.m., R10 was sitting in room ching TV. At 9:23 a.m., R10 eauty salon. At 10:15 a.m., in the beauty shop to the R10 attended an activity. At is moved from the dining room is from the nurses station. At ector of Nursing (DON) or room. The DON indicated is stant would be "checking" in nursing assistant (NA) -C it (lift used to aid in a transfer, ent hold onto the lift and assist the room. R10 was ositioned onto the bed.  Cat 11:47 a.m., revealed R10 ing every two hours and that is sitioned after breakfast, right beauty shop.	2 900	DEFICIENCY)		
	pressure ulcer deve					
2 910	MN Rule 4658.0525 Incontinence	5 Subp. 5 A.B Rehab -	2 910		3	3/22/16

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/11/2016	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Subp. 5. Incontined have a continuous management to recunnecessary use of comprehensive resulting home must ensure	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing	2 910			
	without an indwellin unless the resident that catheterization B. a resident wh receives appropriat prevent urinary trace	ig catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to infections and to restore as er 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.			Corrected		
	Findings include:					
	12/16/15, indicated required extensive bed mobility, transfand was always incadmission MDS dawas frequently incocorresponding Caredated 9/19/15, indicincontinent of urine	imum Data Set (MDS) dated R65 was cognitively intact, assistance of one person with erring, dressing and toileting, ontinent of urine. R65's prior ted 9/12/15, indicated R65 ntinent with urine. R65's e Area Assessment (CAA) cated R65 was frequently, received extensive eting, changing and pericare				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00935	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	after incontinent ep staff to see care plate R65's care plan rev R65 to have freque required extensive pericare after incontinence, princontinent episode needed.  R65's activities of d9/12/15, indicated Fincontinent, was on and utilized liners/bundated care sheet of 1 person and direand check for incontinent was on and check for incontinent was on and utilized liners/bundated care sheet of 1 person and direand check for incontinent was and cares. During the wet and incontinent be wet and incontinent the cares. After NA was ambulated to the tand then wheeled the tand then wheeled the tand then wheeled to tand the was an electron wa	isodes. R65's CAA directed an for goals and interventions. Tised on 12/29/15, identified nt incontinence of bladder and assist with changing and tinence. Interventions oilet every 2 hours and check ovide thorough skin care after as and apply barrier cream as laily living assessment dated as she was occasionally a scheduled toileting plan, riefs. A nursing assistant's indicated R65 required assist ected to toilet every two hours attinence.  a.m. R65 was observed lying neontinent brief. Nursing as in room and getting ready to be cares, R65 was observed to ent brief was changed during the cares, R65 he weighing scale, weighed to the dining room at a.m.	2 910	DEFICIENCY)		
	lying in bed until 10 was observed enter	:38 a.m. At 10:38 a.m. NA-B ring R65's room, offered R65 the room. R65 was not				

	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00935	B. WING	<del></del>	02/1	1/2016
	F PROVIDER OR SUPPLIER EN LIVINGCENTER - LY	NWOOD 5700 EAS	DRESS, CITY, S T RIVER RO MN 55432	STATE, ZIP CODE P <b>AD</b>		
(X4) IC PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 91	offered or prompted R65's incontinent bor changed.  NA-A was interview R65 needed help wis incontinent of urit offered or taken to and had not been to assisted out of bed confirmed R65 was assistance from 7:2 explained that, "we every 2 hrs but I as to NA-B) will becaue explained that she to help him."  R65 was interviewed that he was wet and him or change his becaue him or change his becaue when the change me when the At 11:26 a.m. NA-A incontinent care to was heavily saturat.  NA-B was interviewed that R65 is usually she had not toileted.  Registered nurse (F2/10/16, at 2:06 p.n. directs to check and expectations were to so. RN-A stated "I expectations"	d to use the toilet nor was rief checked for incontinence and the checked for and toileting and the checked for going to be and the toilet before going to be and the toilet before going to be and the checked for an another checked to the toilet since being over three hours prior. NA-A not provided toileting and the other girl (referring seal of the checked for an another checked for an another checked for an another checked and the checked for an another checked for another checked for an another checked for an another checked for an another checked for another checked for an another checked for another checked for another checked for another checked fo	2 910			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	Continued From page 19		2 910			
	plan directed staff hours and check fo "My expectation is to plan and do as it sate to ileted every two have done that."  A facility's Incontine Function Guideline purpose as "Managor maintain as much possiblerestore the policy directed staff to ileting times speciand record the residence.	wed. Confirmed R65's care to assist to toilet every two r incontinence. DON stated that they should follow the care tys. If resident is supposed to o hours, I expected staff to ence Management/Bladder dated 6/9/15, identified the ge urinary incontinence, restore h normal bladder function as the resident's dignity." The to "Develop a schedule of ific to the residentObserve dent's voiding pattern and schedule to meet the needs."				
	The director of nursial residents who reincontinence care the necessary treat much normal bladd director of nursing or random audits of thappropriate care ar	THOD OF CORRECTION: sing or designee, could review accive assistance with to assure they are receiving ment/services to to restore as er function as possible. The or designee, could conduct the delivery of care, to ensure and services are implemented.				
2 915	Subp. 6. Activities comprehensive res home must ensure	of daily living. Based on the ident assessment, a nursing that: given the appropriate	2 915			3/22/16

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING	B. WING		1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 02/1	1/2010
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO	AD		
0/4) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	MN 55432	PROVIDER'S PLAN OF CORRECTION	<b></b>	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 915	Continued From page 20		2 915			
	abilities in activities deterioration is a not the resident's condipart, activities of daresident's ability to:  (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	ss, and groom; d ambulate;				
	by: Based on observati review the facility fa hygiene care for 1 or required extensive cares.  Findings include: R37 was admitted t includes muscle we and dysphagia.  R37's quarterly Min 11/17/15, identified with assist with bed eating, toileting and R37 is severely imp			Corrected		
		ssignment sheet undated, vities of daily livings) A-1				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00935	B. WING		02/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 21	2 915			
	identified R37 had related to: Self care advanced dementia retardation). I will m function. ADLS: ass PRN (as needed) w bathing".  On 2/08/16 at 6:00 interview R37, she gray/white facial had chin area.  On 2/9/16 9:25 a.m several white grayis	ion goal dated 2/2016, Physical functioning deficit impairment related to a secondary to MR (mental naintain my current level of sist x 1, A-2 (assist of two) with bed mobility, toileting and p.m., during an attempt to was observed to have several irs to the upper lip and the  c, R37 was observed to have sh facial hairs to the upper lip while sitting in wheelchair in her				
	room.	m. R37 was observed in her				
		wheelchair and was observed				
	verified R37 was ur expectation was the be shaven as need	a.m. registered nurse (RN)-A nshaven and indicated her at residents were supposed to ed per care plan. In addition, ng is part of ADL care plan.				
	R37 was unshaven	a.m., RN-B acknowledged and indicated the expectation were supposed to be shaved				
		a.m. director of nursing pectation was that residents is needed.				
	Policy and procedu	re titled SHAVING THE				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

_	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7110 1 2711	OF CONTILECTION	BENTI IOMION NOMBER.	A. BUILDING:	A. BUILDING:		LLTLD
		00935	B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NWOOD	T RIVER RC MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ige 22	2 915			
		2006, indicated, "To remove ove the resident's appearance				
	director of nursing a or revise policies, a regarding resident Assurance and Per	THOD OF CORRECTION: The and/or designee could review and provide education for staff grooming. The Quality formance Improvement(QAPI) or random audits to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			3/22/16
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observat review, the facility f care and services f	ent is not met as evidenced ion, interview, and document ailed to provide necessary or urinary incontinence for 1 of no was dependent on staff for		Corrected		
	Findings include:					
		narterly minimum data set 6 indicated R10 was frequently				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		00935	B. WING		02/1	1/2016	
	PROVIDER OR SUPPLIER	NWOOD 5700 EAS	DRESS, CITY, S T RIVER RO MN 55432	TATE, ZIP CODE AD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 920	incontinent of urine assistance with toile assist. The care ar the annual MDS da was incontinent of brequired staff assist checking resident e PRN (as needed)".  Review of R10's plaindicated the follow of bowel and urinary in ADL's (activities of frquently (sic) to alv bladder." Interventi (every) 2 hours and "toileting assist: Tot On 2/10/16 at 9:00 in wheelchair watch was taken to the be R10 was taken fron dining room where 11:08 a.m., R10 was to the hallway, acro 11:33 a.m., the Dire brought R10 back to nursing assistant wil:40 a.m., nursing Sara lift (lift used to the resident hold or standing) into the roonto the bed, NA-C incontinence brief, a Interview with NA-C was "check and characteristics."	and required extensive eting with one person physical ea assessment (CAA) from ted 4/23/15, indicated R10 powel and bladder, and it with incontinence cares "by every two hours and change an of care revised on 1/18/16 ing: "Alteration in elimination er Functional and mixed incontinence, dependence in daily living). Resident is evays incontinent of bowel and ons included "Check Q I change PRN (as needed)". al assist of 1 staff member."  a.m., R10 was sitting in room and explained an activity. At some moved from the dining room in the beauty shop to the R10 attended an activity. At some moved from the dining room as from the nurses station. At actor of Nursing (DON) or room and explained that the ould be "checking" R10. At assistant (NA) -C brought the aid in a transfer, by having to the lift and assist with from. R10 was transferred removed the saturated and applied a new brief.	2 920				
		ng every two hours". NA-C					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935			02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	.,
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 24	2 920			
	again until now, (2) SUGGESTED MET The DON or design as necessary the p regarding the need change programs. could provide traini these policies and p designee (s) could are receiving adequ	beauty shop and not checked nours 40 minutes later).  THOD OF CORRECTION: tee(s) could review and revise policies and procedures for assistance with check and The DON or designee (s) the polygon of the				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident himmunization progradefined in part 465 procedures of residulation and F. the developing the prevention and F. the developing the procedures which is the procedures of the prevention and F. the developing the procedures which is the developing the procedures which is the procedures of the prevention and the procedures of the prevention and the preve	O Subp. 4 A-I Infection Control and procedures. The infection ast include policies and provide for the following: based on systematic data anosocomial infections in detection, investigation, and so of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control	21390			3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED	
		00935	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - LY	NWOOD	ST RIVER RO 7, MN 55432	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	practices, including defined in part 4658 G. a system for H. a system for products which affed disinfectants, antise incontinence product. In methods for a current standards of the current standar	a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of act infection control, such as eptics, gloves, and cts; and maintaining awareness of a practice in infection control.  The process of a process of a practice in infection control.  The process of a		Corrected		

Minnesota Department of Health

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PRINTED: 03/04/2016 FORM APPROVED

Minnesc	<u>ota Department of He</u>	ealth					
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935		B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LY	'NWOOD		T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 26		21390			
	abdominal area. NA brief, which was ob with urine. NA-A pla garbage bag. Without asked R65 to turn to wash R65's back at using the same was R65's bottom, with opened a top drawe into the bottom of the Durable barrier cream onto her har applied the cream to dirty gloves, NA-A grabb sitting on R65's who resident. NA-A then from w/c and dress gloves. Using the sopened R65's beds the other and stated R65's socks. NA-A same dirty gloves a socks, touching and around. NA-A grabb sitting on w/c, held helped R65 to put to NA-A opened R65's comb and combed hair and head. NA-A using same gloves, an emesis basin from R65's toothpaste are to ambulate R65 to the toothbrush and	R65's arms, underarm A-A removed R65's inconserved to be heavily staced the soiled brief it but changing gloves, Not the wall and proceed and performed perineal sh cloth. After NA-A clothe same soiled glove er of R65's bedside state drawer and pulled of am (Cavilon), squeezed (Cavilon), squeezed (With dirty gloves of R65's back. With the eturned the cream tubeser. With the same directly gloves, NA-A side dresser drawers of that she was looking then opened R65's pant and proceeded to seared moving R65's clothing the bottom of shoes a hem on. With same gest top drawer, pulled our R65's hair, touching R65's hair,	continent caturated in the NA-A ded to I cares leansed es, NA-A and, dug out a led the on) and e same of to rty leat was it on leand shirt irty A leand shirty A leand shirt				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00935	B. WING	<del></del>	02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
GOLDE	N LIVINGCENTER - LY	NWOOD	ST RIVER RO , MN 55432	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21390	At 8:06 a.m. NA-A with she never changed during the entire per explained that she is before and after we get dirty and before NA-A stated "I totall supposed to be tous guess I got nervous had received infections and received infections are supposed to adhere the control of the control polyminimum, she expectations was infection control polyminimum, she expectations was infection control polyminimum, she expectanged gloves and "moving from dirty the control and regular importance of hand transmission of head all personal shall for hygiene procedures infections to other procedures infections to other procedures to control techniques in followed. Facility standard procedures to control techniques in followed.	was interviewed. Verified that gloves nor washed hands ersonal care process. NA-A is supposed to wash hands earing gloves, when the gloves touching clean surfaces. By forgot. I know I wasn't ching stuff with dirty gloves. I s." NA-A confirmed that she ion control training and is to it.  1 a.m. director of nursing wed. explained that staff have infection control. DON stated as that all staff follow the licies. DON stated that at a exted the NA-A to have d washed hands when to clean."  Shing/Hand hygiene policy d that "All personal shall be by in-serviced on the latthcare-associated infections. Sollow the handwashing/hand is to help prevent the spread of personal, residents, and	21390			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NWOOD	T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 28	21390			
	Time Period for Codays.	rrection: Twenty one (21)				
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426			3/22/16
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumelith shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of eation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.				
	by: Based on interview facility failed to ens Employee Tubercul Tuberculin Skin Tes evaluations for 3 of	ent is not met as evidenced and document review, the ure State guidelines to ensure osis (TB) Screening, st (TST) and medical 5 employees (E1, E2, E3) or to working in the facility.		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00935	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	INWOOD	ST RIVER RO , MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From pa	age 29	21426			
	2/10/16, at around E-1 had a start date screen and first-ste with an induration conterpretation reading a blood test or a che-2 had a start date screen and first-ste with an induration or reading of negative or a chest x-ray was tart date of 1/19/1 first-step TST was induration of 0 mm	ee files was conducted on 1:00 p.m. The review revealed e of 11/23/15. A TB symptom ep TST was done on 11/18/15 of zero (0) millimeter (mm) and ng of negative. A second TST, nest x-ray was not completed. e of 11/12/15. A TB symptom ep TST was done on 10/29/15 of 0 mm and interpretation e. A second TST, a blood test as not completed. E-3 had a 6. A TB symptom screen and done on 1/7/15 with an and interpretation reading of TST, a blood test or a chest bleted.				
	nursing (DON) on a verified staff TST was policy. DON explain responsible for tract and testing for staff several months. The know we have a property and two-step TS A facility's Annual TAssessment dated skin testing is performed the employee has a past 12 months)."	onducted with the director of 2/11/16, at 9:15 a.m. The DON vere not completed as per their ned that the development staff cking tuberculosis screening if had quit within the last ne DON acknowledged that "I oblem with that [staff cplained staff are supposed to ST completed.  Tuberculosis (TB) Risk 4/15, directed, "A baseline ormed with a two-step TST for e Workers]. (Note: one test if there is documentation that has a negative TST within the				
		THOD OF CORRECTION: The could in-service the staff				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
I GOLDEN LIVINGCENTER - LYNWOOD			T RIVER RO MN 55432	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 30	21426			
	program to ensure requirements. Audit results brought to the review.  TIME PERIOD FOR	repleting and monitoring the TB it is consistent with current TB is could be conducted and the ne quality committee for				
	(14) days					
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545			3/22/16
	percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long-incorporated by refe purposes of this pa (1) a discrepair prescribed and what administered to rese (2) the administered to reservor. A significant (1) an error of discomfort or jeopal safety; or (2) medication requires the medication error coprecipitate a reoccutoxicity. All medicat prescribed. An incerror report must be	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of s Manual, Guidance to Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
NAME OF PROVIDER OR SUPP	.IER		, ,	STATE, ZIP CODE		
GOLDEN LIVINGCENTER	- LY	NWOOD	T RIVER RO MN 55432	AD		
PREFIX (EACH DEFIC	ENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
physician or the resident or the designated reg must be made  C. All med prescribed. An report must be occurs. Any s resident reactiphysician or the designated reg must be made  This MN Requiby: Based on obserview, the fact were administed residents (R77 administration medication error Findings included R77's signed principal indicated R77 Solution, inject meals.  On 2/10/16, at (LPN)-B was consulin FlexPercap off, cleans and dialed up a signed principal indicated R79.	ns rephrese photostering in the residual residua	must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. Ons are administered as ident report or medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record.  The provided the provided to the entative and an explanation he resident's clinical record.  The provided to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record.  The provided to the ysician's clinical record.	21545	Corrected		

Minnesota Department of Health

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00935	B. WING		02/1	1/2016
	PROVIDER OR SUPPLIER	NWOOD 5700 EAS	DRESS, CITY, S T RIVER RO MN 55432	STATE, ZIP CODE AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21545	seated on bed. LPN clean gloves, clean ready to inject insul prime Flexpen first insulin dose. When primed Flexpen, stainsulin pen with 2 u  R11's signed physic indicated R11 had a Solution 100 unit/m one time a day for I 2) with breakfast, L Pen-injector 100 un acting insulin) inject the morning for DM than 70, Novolog F	I-B washed hands, applied sed R77's abdomen and was in. LPN-B was not observed to before dialing up required asked LPN-B if she had ated no, she forgot to prime	21545			
	dated 2/11/15, indicunit/ml (Insulin Glar subcutaneously two FlexPen solution per Aspart) inject 5 unit for DM, hold if BS (and Novolog FlexPer unit/ml (Insulin Aspart) aunits, su DM. Blood glucose On 2/10/16, at 8:29 wash hands, obtain medication cart, too seal, applied needle scheduled with measure soloStar FlexPer and the solo Star Flex And the solo Star FlexPer and th	o times a day for DM, Novolog en-injector 100 unit/ml (insulin s subcutaneously with meals blood sugar) less than 120, en solution pen-injector 100 art) inject as per sliding scale, ubcutaneously with meals for				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00935	B. WING		02/1	11/2016
	PROVIDER OR SUPPLIER	NWOOD 5700 EAS	DDRESS, CITY, S ST RIVER ROA , MN 55432	TATE, ZIP CODE AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21545	needle, dialed up 1: two times a day. LF glucometer, alcoho and entered room w wheelchair. LPN-A gloves, and cleanse not observed to prin dialing up required LPN-A if she had pr dialing insulin dose she should prime F gloves, left room, d container, alcohol w needles and prime room, washed hand wiped R11's abdom  On 2/10/16, at 8:41 remembered there prime insulin pens a primed the pens first On 2/10/16, at 12:0 director of nursing ( nurses to prime insu up insulin for injecti  On 2/11/16, at 12:2 (CP) stated nurses pens first so reside amounts.  A facility insulin poli provided.  Facility provided No Instructions/Using to 2/10/16, which direct "Step 2: Doing the a	2 units of insulin scheduled PN-A gathered clean I wipes, cotton balls, Flexpens where R11 was seated in her washed hands, applied clean ed R11's abdomen. LPN-A was me Flexpens first before insulin doses. When asked, rimed Flexpens first before s, LPN-A stated was not aware lexpens first. LPN-A removed iscarded needles in sharps wiped Flexpens, applied new d Flexpens. LPN-A entered ds, applied gloves, alcohol in and injected insulin.  a.m. LPN-A stated she just was an in-service on how to and stated she should have st.  0 noon when interviewed, (DON) stated she expected ulin pens first before drawing ons.  4 p.m. consultant pharmacist should always prime insulin ints obtain correct insulin  cy was requested but none				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00935	B. WING		02/	11/2016
	PROVIDER OR SUPPLIER	NWOOD 5700 EAS	DRESS, CITY, S T RIVER RO , MN 55432	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21545	during normal use. ensure proper dosir -Turn the dose sele -Hold your FlexPen and tap the cartridg moves the air bubb -Press the push-but dose selector is bad should appear at th -If no drop appears repeat. If you still do after 6 tries, do not Novo Nordisk at 1-8 bubble may remain be injected"  SUGGESTED MET The administrator a could review and re to ensure facility wa The consultant pha licensed staff to pro error. The director compliance.	To avoid injecting air and ng: ctor to 2 units with the needle pointing up, e gently a few times, which les to the top tton all the way in until the ck to 0. A drop of insulin	21545			

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