DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: C98F

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00936 1. MEDICARE/MEDICAID PROVIDER 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: **7**(L8) (L3) GOLDEN LIVINGCENTER - LA CRESCENT 245319 NO.(L1) 1. Initial 2. Recertification (L4) 101 SOUTH HILL STREET 4. CHOW 3. Termination 2. STATE VENDOR OR MEDICAID NO. (L6) **55947** (L5) LA CRESCENT, MN 5. Validation 6. Complaint 486728900 (L2)7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 04/01/2006 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF $\boldsymbol{11/15/2016}^{\text{L}34)}$ 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: From (a): X A. In Compliance With ____ 2. Technical Personnel To (b): Program Requirements Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 45 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 45 (L17) 13. Total Certified Beds B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18/19 SNF 19 SNF ICF IID (L15)18 SNF 1861 (e) (1) or 1861 (i) (1): 45 (L37) (L38) (L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval. 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Connie Brady, HFE NE II 12/15/2016 Kamala Fiske-Downing, Enforcement Specialist 12/15/2016 (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 07/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00454 (L31) (L28) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245319

December 13, 2016

Ms. Abby Rand, Administrator Golden LivingCenter - La Crescent 101 South Hill Street La Crescent, MN 55947

Dear Ms. Rand:

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 November 11, 2016 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

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

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 12, 2016

Ms. Abby Rand, Administrator Golden LivingCenter - La Crescent 101 South Hill Street La Crescent, MN 55947

RE: Project Number S5319025

Dear Ms. Rand:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 26, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

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

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

This was based on the deficiencies cited by this Department for a standard survey completed on August 26, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 18, 2016. The most serious deficiencies at the time of the revisit were found 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 November 15, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 15, 2016, as of November 11, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 11, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 25, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective

Golden Livingcenter - La Crescent December 12, 2016 Page 2

November 26, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 26, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 26, 2016, is to be rescinded.

In our letter of October 25, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 26, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 11, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect.

Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

Golden Livingcenter - La Crescent December 12, 2016 Page 3 Golden Livingcenter - La Crescent December 12, 2016 Page 4

		POST-C	ERTIFI	CATION	N REVISIT F	REPORT		
PROVIDER /			STRUCTION				DATE (OF REVISIT
245319	I ION NOMBE	A. Building Y1 B. Wing					_{Y2} 11/15/	2016 _{Y3}
NAME OF FA	ACILITY				STREET ADDRESS, C	CITY, STATE, ZIP CO	DE	
GOLDEN L	IVINGCENT	ER - LA CRESCENT			101 SOUTH HILL STR			
					LA CRESCENT, MN 5	5947		
program, to corrected a	show those nd the date umber and t	d by a qualified State sue deficiencies previously such corrective action whe identification prefix c	reported on the reported reported in the reported repo	he CMS-2567 hed. Each de	7, Statement of Defici eficiency should be fu	iencies and Plan of ully identified using	Correction, tha either the regul	t have been ation or LSC
ITEM		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix F0)312	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	3.25(a)(3)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		11/11/2016	LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
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Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC _			LSC			LSC		=
REVIEWED	DV	REVIEWED BY	DATE	SIGNATU	RE OF SURVEYOR		IDATE	

FOLLOWUP TO SURVEY COMPLETED ON 8/26/2016 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

12/12/2016

DATE

DATE

11/15/2016

YES NO

28651

STATE AGENCY

REVIEWED BY

CMS RO

(INITIALS) GPN/kfd

REVIEWED BY

(INITIALS)

TITLE



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 13, 2016

Ms. Abby Rand, Administrator Golden LivingCenter - La Crescent 101 South Hill Street La Crescent, MN 55947

RE: Project Number S5319025

Dear Ms. Rand:

On October 25, 2016, this Department recommended the following action to the CMS RO for imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 26, 2016. (42 CFR 488.417 (b))

Also, on October 25, 2016, we informed you that the following enforcement remedy was being imposed:

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

This was based on the deficiencies cited by this Department for a standard survey completed on August 26, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 18, 2016. The most serious deficiencies at the time of the revisit were found 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 November 15, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 15, 2016, as of November 11, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 11, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 25, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Golden LivingCenter - La Crescent December 13, 2016 Page 2

> Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 26, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 26, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 26, 2016, is to be rescinded.

In our letter of October 25, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 26, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 11, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

Golden LivingCenter - La Crescent December 13, 2016 Page 3 Golden LivingCenter - La Crescent December 13, 2016 Page 4

	STATE FORM: REVISIT REPORT										
	ER / SUPPLIER CATION NUME		ISTRUCTION				Y2	DATE OF REVISIT 11/15/2016 _{Y3}			
	F FACILITY N LIVINGCEN	TER - LA CRESCENT			STREET ADDRESS, C 101 SOUTH HILL STR LA CRESCENT, MN 5	EET					
correctiv	e action was ation prefix co	ed by a State surveyor to accomplished. Each def de previously shown on t	iciency should be	fully iden	tified using either the	regulation or	LSC provision	n number and the			
ITE	М	DATE	ITEM		DATE	ITEM		DATE			
Y4		Y5	Y4		Y5	Y4		Y5			
ID Prefix	20860	Correction	ID Prefix		Correction	ID Prefix		Correction			
Reg. #	MN Rule 4658 Subp. 2 F.	.0520 Completed	Reg. #		Completed	Reg. #		Completed			
LSC		11/11/2016	LSC			LSC					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction			
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed			
LSC			LSC			LSC _		·			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction			
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed			
LSC			LSC			LSC _					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction			
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed			
LSC			LSC			LSC					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction			
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LSC			LSC			LSC					
						_					
REVIEWI STATE A		REVIEWED BY (INITIALS) GPN/kfd	DATE 12/13/2016	SIGNATU	IRE OF SURVEYOR 28651			DATE 11/15/2016			
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE			
FOLLOW 8/26/201	VUP TO SURVE			CORRECTED DEFICIENCIES (CMS-2567)			YES NO				

Page 1 of 1 EVENT ID: C98F13

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1 TJC

18/19 SNF

45

(L38)

3 Other

245319

486728900

8. ACCREDITATION STATUS:

(a):

(b):

12. Total Facility Beds

13. Total Certified Beds

18 SNF

(L37)

17. SURVEYOR SIGNATURE

11. .LTC PERIOD OF CERTIFICATION

(L9) **04/01/2006**

6. DATE OF SURVEY

0 Unaccredited

2 AOA

From

To

NO.(L1)

(L2)

CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: C98F PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00936 1. MEDICARE/MEDICAID PROVIDER 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: **7**^(L8) (L3) GOLDEN LIVINGCENTER - LA CRESCENT 1. Initial 2. Recertification (L4) 101 SOUTH HILL STREET 4. CHOW 3. Termination 2. STATE VENDOR OR MEDICAID NO. (L6) **55947** (L5) LA CRESCENT, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF $\boldsymbol{10/18/2016}^{\text{L}34)}$ 14 CORF FISCAL YEAR ENDING DATE: (L35)__ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 12/31 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: ____ 2. Technical Personnel Program Requirements 6. Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 45 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 45 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)B. 5 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): (L39) (L42)(L43) Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval. 18. STATE SURVEY AGENCY APPROVAL

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

Wendy Buckholz, F		- 11/3/2016 (L19)	Kamala Fiske-Downing, Enforce	(L20)
P	ART II - TO BE COMP	LETED BY HCFA REGIONA	AL OFFICE OR SINGLE STATE A	AGENCY
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 21. 1. Statement of Financial Solve 2. Ownership/Control Interest 3. Both of the Above : 	
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986	23. LTC AGREEMENT BEGINNING DATE	24. LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVE SAN A. Suspension of Admi B. Rescind Suspension	ssions: (L44)	02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 00454 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE			30. REMARKS	
	(L32)	(L33)	DETERMINATION APPROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

October 25, 2016

Ms. Abby Rand, Administrator Golden LivingCenter - La Crescent 101 South Hill Street La Crescent, MN 55947

RE: Project Number S5319025

Dear Ms. Rand:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 26, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 18, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 26, 2016. The deficiencies not corrected are as follows:

F0312 483.25(a)(3) -- Adl Care Provided For Dependent Residents S/S: D

The most serious deficiencies in your facility were found 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.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

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

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 26, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 26, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 26, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - La Crescent is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 26, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 February 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 12/19/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SI COMPLE	
		245319	B. WING		R	/0016
NAME OF F	PROVIDER OR SUPPLIER	243013		STREET ADDRESS, CITY, STATE, ZIP CODE	10/18/	/2016
GOLDEN	LIVINGCENTER - LA	CRESCENT		101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOU) TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE C	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F0	00		
	completed on Octol tags that were corrected. Also the found corrected at the is located on the CN Because you are ensignature is not req	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as				
{F 312} SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.25(a)(3) ADL CODEPENDENT RES A resident who is useful daily living receives	acceptable electronic POC, an ar facility will be conducted to nitial compliance with the en attained in accordance with EARE PROVIDED FOR IDENTS hable to carry out activities of the necessary services to tion, grooming, and personal	{F 31	2}	11	1/11/16
	by: Based on observate review, the facility faci	NT is not met as evidenced ion, interview and document ailed to provide nail and hand esidents (R9 and R12) who eed assistance by staff to of daily living (ADL's) needs.		 Nail care and hand hygiene hav provided for R9 and R12. Residents who are unable to car activities of daily living have the pot to be affected. Education has been provided to staff on providing dependent reside 	ry out tential nursing	

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

TITLE

(X6) DATE

Electronically Signed

11/01/2016

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

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

PRINTED: 12/19/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		245319	B. WING				∃ 18/2016
	PROVIDER OR SUPPLIER	A CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HILL STREET A CRESCENT, MN 55947	10/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 312}	to be located in the observation R12 was fingernails which has nails as well on several palm protector in plant protector in pl	erved on 10/17/16, at 2:47 p.m. dining room. During as noted to have very long ad brown debris underneath veral cuticle areas. R9 had a lace on left hand and when dithere was a foul odor coming at the was a foul odor coming and a.m. R12 was observed emained long with debris palm protector was in place and when left hand was plooking and a very strong noted. R12 stated staff had splint] on my hand. I am hat on and my hand washed." I wrovided per R12. Simum Data Set (MDS) 8/10/16, included a Brief I. Status (BIMS) assessmenting moderate cognitive DS also identified that R12 assistance with ADL needs	{F 3-	12}	assistance they need to meet their activities of daily living needs. 4. DNS or designee will completed random audits of dependent reside nail care weekly X 4 weeks, then m X 2 months. Results will be communicated to facility QAPI com	ent's nonthly	

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

PRINTED: 12/19/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245319	B. WING				R 18/2016
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	10/	18/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 312}	hand hygiene. When interviewed of assistant director of the odor coming frostaff should have wher palm protector. fingernails were not nail care provided property of the seated in a reseveral long chin has fingernails had black underneath nails. On 10/18/16, at 10: observed sitting in a removed however, have black and brown as the significant characteristic of the severe cognitive imidentified R9 with a Status (BIMS) score severe cognitive imidentified that R9 with a Status (BIMS) score severe cognitive imidentified R9 receives mornings. Review of 10/16/16, identified bath schedule ident REMEMBER TO Deplan revised 9/19/16	on 10/18/16, at 10:30 a.m. the foursing (ADON) confirmed and R12's left hand and stated ashed her hand and applied She also confirmed R12's cleaned and should have had ber the plan of care. Ved on 10/17/16, at 3:19 p.m. cliner. R9 was noted to have air on the left side of chin and k and brown debris 39 a.m. R9 was again a recliner. Chin hairs had been the fingernails continued to wn debris underneath nails. Inge MDS dated 9/5/16, Brief Interview for Mental a of 4 indicating R9 had pairment. The MDS also as totally dependent on staff	{F3	12}			

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

PRINTED: 12/19/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		245319	B. WING				R 18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 101 SOUTH HILL STREET LA CRESCENT, MN 55947	CODE	<u> 10/</u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
{F 312}	assistant director of R9's nails were soil on 10/16/16, and na performed but had Review of the facilit reviewed 12/7/15, in To Give special care hands and feet. Als	on 10/18/16, at 10:30 a.m. the f nursing (ADON) confirmed ed. She verified R9 had a bath ail care should have been not.	{F 3	12}			

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
IDENTIFICATION NUMBER 245319 Y1	A. Building B. Wing		Y2	10/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - LA	CRESCENT	101 SOUTH HILL STREET			
		LA CRESCENT, MN 55947			

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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0157	Correction	ID Prefix F022	25	Correction	ID Prefix	F0226		Correction
Reg. #	483.10(b)(11)	Completed	Reg. # 483.1	13(c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC		09/23/2016	LSC		09/23/2016	LSC			09/23/2016
ID Prefix	F0282	Correction	ID Prefix F030	09	Correction	ID Prefix	F0323		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. # 483.2	25	Completed	Reg. #	483.25(h)		Completed
LSC		09/23/2016	LSC		09/23/2016	LSC			09/23/2016
ID Prefix	F0431	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.60(b), (d), ((e) Completed	Reg. #		Completed	Reg. #			Completed
LSC		09/23/2016	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE 10/25/2016	SIGNATURE OF	SURVEYOR 3176	S7		DATE 10	/18/2016
REVIEWI CMS RO	ED BY	GPN/kfd REVIEWED BY (INITIALS)	DATE	TITLE	3170	<i>,</i>		DATE	10,2010
FOLLOWUP TO SURVEY COMPLETED ON 8/26/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO					s 🗆 NO		

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

C98F12



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on November 15, 2016.

November 15, 2016

Ms. Abby Rand, Administrator Golden LivingCenter - La Crescent 101 South Hill Street La Crescent, MN 55947

Re: Project # \$5319025

Dear Ms. Rand:

On October 18, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 26, 2016 with orders received by you electronically on September 12, 2016.

State licensing orders issued pursuant to the last survey completed on August 26, 2016 and found corrected at the time of this October 18, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on August 26, 2016, found not corrected at the time of this October 18, 2016 revisit and subject to penalty assessment are as follows:

20860 - MN Rule 4658.0520 Subp. 2.F - Adequate and Proper Nursing Care; Hands-Feet - \$350.00

The details of the violations noted at the time of this revisit completed on October 18, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the

Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at:

> **Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast** Rochester, Minnesota 55904

Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit **Health Regulation Division**

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

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

PRINTED: 12/19/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X3) DAT COM		
		00936	B. WING		R 10/18/2	2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL		STATE, ZIP CODE	10,10,1	
GOLDEN	LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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)	LD BE C	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficient herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	INITIAL COMMENT	ΓS:				
2 860	Proper Nursing Car		2 860			
		or determining adequate and riteria for determining				

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

11/01/16 **Electronically Signed**

TITLE

PRINTED: 12/19/2016 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	(3) DATE SURVEY COMPLETED	
		00936	B. WING			R 18/2016	
	PROVIDER OR SUPPLIER	STREET AD 101 SOU	DDRESS, CITY, S TH HILL STR CENT, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 860	adequate and prope E. per care and att Fingernails and toe trimmed.		2 860				

Minnesota Department of Health

		STATE FORM: F	REVISIT REPORT						
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 00936 y1	MULTIPLE CON A. Building B. Wing	STRUCTION		Y2	DATE OF REV 10/18/2016	ISIT Y3			
NAME OF FACILITY GOLDEN LIVINGCENTER - LA CRESCENT STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947									
This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).									
ITEM	DATE	ITEM	DATE	ITEM	DATE	:			

-	,										
ITEM			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	MN Rule 4658.0	0085	Completed	Reg. #	MN Ru Subp. :	lle 4658.0405 3	Completed	Reg. #	MN Rule 4658.05 Subp. 1	520	Completed
LSC			09/28/2016	LSC			09/28/2016	LSC			09/28/2016
ID Prefix Reg. #	21426 MN St. Statute Subd. 3	144A.04	Correction Completed	ID Prefix Reg. #	-	le 4658.1340	Correction	ID Prefix Reg. #	21915 MN St. Statute 14 Subd. 27	14.651	Correction Completed
LSC			09/28/2016	LSC			09/28/2016	LSC			09/28/2016
ID Prefix Reg. # LSC	21980 MN St. Statute Subd. 3	626.557	Correction Completed 09/28/2016	ID Prefix Reg. # LSC	MN St.	Statute 626.557 14 (a)-(c)	Correction Completed 09/28/2016	ID Prefix Reg. # LSC			Correction Completed
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
ID Prefix Reg. #			Correction Completed	ID Prefix Reg. #			Correction	ID Prefix Reg. #			Correction Completed
LSC			oop.o.oo	LSC	-		-	LSC			
				200				100			
REVIEWED BY STATE AGENCY (INITIAL GP			DATE 10/25/2016		SIGNATURE OF SURVEYOR		31767		DATE 10/18/2016		
REVIEWI CMS RO		REVIEW (INITIAL	ED BY	DATE	_0.10	TITLE				DATE	. 3/2010
FOLLOW 8/26/201	ETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES						s 🗆 NO			
						Page 1 of 1			EVENT ID:	C98F12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: C98F

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY	THE STAT	ΓE SURVEY AGENCY		Facility ID: 00936		
MEDICARE/MEDICAID PROVI	DER	3. NAME AND AI			4. TYPE OF ACTION: 2 (L8)				
NO.(L1) 245319		(L3) GOLDEN L			1. Initial	2. Recertification			
2. STATE VENDOR OR MEDICAL (L2) 486728900	D NO.	(L4) 101 SOUTH (L5) LA CRESC		EΤ	(L6) 55947	3. Termination 5. Validation	4. CHOW6. Complaint		
5. EFFECTIVE DATE CHANGE O	F OWNERSHIP	7. PROVIDER/SU	UPPLIER CATE	GORY	<u>02</u> (L7)	7. On-Site Visit	9. Other		
(L9) 04/01/2006		01 Hospital 05 HHA 09 ESRD			13 PTIP 22 CLIA	8. Full Survey After Complaint			
6. DATE OF SURVEY 08	/26/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGGAL WEAD END	DIG DATE (L25)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR END	ING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31			
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	Y IS CERTIFIED	AS:					
From (a):	A. In Complia	ance With		And/Or Approved Waivers Of The Following Requirements:					
To (b):	To (b):								
10 Terel Franker Dada	45 (J.19)	1. A	Acceptable POC		4. 7-Day RN (Rural SI	NF) 8. Patient Roo	om Size		
12.Total Facility Beds 13.Total Certified Beds	45 (L18) 45 (L17)	X B. Not in Cor	mmlion oo yyith Duo		5. Life Safety Code	9. Beds/Room	n		
13. Total Certified Beds	43 (L17)		mphance with Pro s and/or Applied	~	* Code: B. 5	(L12)			
14. LTC CERTIFIED BED BREAKE	OOWN	<u> </u>			15. FACILITY MEETS				
18 SNF 18/19 SNI	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
45									
(L37) (L38)	(L39)	(L42)	(L43)						
Documentation supporting the 17. SURVEYOR SIGNATURE	facility's reques	t for a continuing	g waiver invo	olving LSC	C K67 is being recommen		to CMS for approva		
Pamela Manzke, H	FE NE II		09/27/2016	(L19)	Kamala Fiske-Downing,	Enforcement Spec	<u>sialist</u> 10/25/2016		
P	ART II - TO BE	COMPLETED	BY HCFA R	` ′	L OFFICE OR SINGLE S	STATE AGENCY	(LZC		
19. DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible.	Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
	(L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION		(L30)		
OF PARTICIPATION 07/01/1986			ENDING DA	ATE	VOLUNTARY 00 01-Merger, Closure		NTARY Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	on <u>OTHER</u>			
	A. Suspension	n of Admissions:	Admissions:		04-Other Reason for Withdrawal	07-Provid	der Status Change		
(L27)		(L44)				00-Active	e		
(127)	B. Rescind Su	spension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY			30. REMARKS				
		00454							
	(L28)	VV+34		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVA	L DATE					

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 12, 2016

Ms. Abby Rand, Administrator Golden LivingCenter - La Crescent 101 South Hill Street La Crescent, Minnesota 55947

RE: Project Number S5319025

Dear Ms. Rand:

On August 26, 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. In addition, at the time of the August 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

Gary Nederhoff, Unit Supervisor Rochester Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: gary.nederhoff@state.mn.us

Phone: (507) 206-2731 Fax: (507) 206-2711

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 October 5, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 5, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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 November 26, 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 February 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

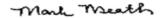
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Golden LivingCenter - La Crescent September 12, 2016 Page 6

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 09/26/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245319	B. WING _	·····	08/	/26/2016	
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	ΓS of correction (POC) will serve	F 0	00			
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
F 157	on-site revisit of you validate that substate regulations has been your verification. 483.10(b)(11) NOT		F 1	57		9/23/16	
SS=G	consult with the resknown, notify the resor an interested fan accident involving tinjury and has the pintervention; a signiphysical, mental, or deterioration in heastatus in either life tolinical complication significantly (i.e., a existing form of treatment); or a decithe resident from the §483.12(a).	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ficant change in the resident's respectosocial status (i.e., a lth, mental, or psychosocial threatening conditions or each of the second threatening th					
	and, if known, the r or interested family	so promptly notify the resident esident's legal representative member when there is a					
ARORATOR\	CUIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATLIRE	TITLE		(X6) DATE	

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

Electronically Signed

09/22/2016

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			E SURVEY PLETED
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F 157	specified in §483.1 resident rights under regulations as specithis section. The facility must rethe address and phlegal representative. This REQUIREMENT by: Based on observative review, the facility fapain/injury following who had a fall that in pain related to a frateurther, the facility significant bruising significant change in her room in her vand moaning. An inher restlessness are to respond appropring significant changes significant ch	roommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. AT is not met as evidenced ion, interview and document ailed to notify the physician of a fall for 1 of 3 residents (R9) resulted in harm evidenced by cture of the femur for R9. failed to notify the physician of for 1 of 1 resident (R38) with of unknown origin when ord identified diagnoses and osteoporosis without I fracture. In 8/22/16, at 5:24 p.m. sitting wheelchair. She was restless nterview was attempted about and moaning but R9 was unable itately to questions. Inge Minimum Data Set (MDS) 5/18/16, identified R9 with a Mental Status (BIMS) score of	F 1:	1. Physician has been notificature involving resident Fibruise of unknown origin fo 2. All residents with change had potential to be affected 3. Licensed nursing staff had educated on timely notificat physician of resident with condition. 4. DNS or designee will conducted on the condition weekly for four we monthly for 2 months. Residents with characted to facility Queen the communicated	R9 and our R38. The in cond is a very been too of the hange in the eeks and outs will be an	of lition n n andom d then	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3	B) DATE SURVEY COMPLETED	
		245319	B. WING			08/26/2016	
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		
F 157	associated with the for falls and fall relaextensive assistant. During review of the entries were noted: On 8/21/16, at 9:54 change of condition was documented in transferred from the transfer belt and slibed. The note furth the right side and the bruises on her right arm. The note also pain "all over." On 8/22/16, at 8:53 had complained of and was unable to a full lift to transfer. On 8/22/16, at 4:31 complaining of pain transferring in the Edevice). On 8/22/16, at 10:2 was having marked to utilize the EZ stat transfer safely. The lift was used to transbedtime. R9 was not more of the note on 11:27 per safely.	are Area Assessment (CAA) MDS identified R9 was at risk ated injuries and required se of 2 staff with transfers. In the note identified a situation had occurred. It the note that R9 was being the commode to the bed with a did down on the floor next to her the identified minimal pain to that R9 had reddish colored the upper back under her right identified R9 stated she had a.m. a note identified that R9 right thigh pain at 6:00 a.m., stand and required staff to use	F1	57			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245319	B. WING			08/	26/2016
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F 157	was raised and stafaround the entire howas identified as be measured 6 cm by area was warm to to in pain with use of the gently in bed. On 8/23/16, at 8:35 transferred with a full 8/23/16, at 9:30 a.m pain in her right this having a large hem and movement. R9 was transferred on 8/23/16. A note (ER) dated 8/23/16 right leg was shortenote from 8/23/16, ER identified that R the facility and state fracture of the right from the hospital dap.m.) identified R9 h fracture. The note into skin and R9 demindicators of pain and femur/hip area. During interview on assistant (NA)-I state stated when she trated at the stated was R9 was EZ stand as R9 was stated was R9 was EZ stand as R9 was stated was was R9 was EZ stand as R9 was stated was was R9 was EZ stand as R9 was R	rple hematoma (bruise) that if were able to cup their palm ematoma, The hematoma eing firm to touch and 12 cm. R9's upper trochanter ouch. R9 was noticed to wince he lift as well as when rolled a.m. a note identified R9 was all body lift. A note from in. identified R9 was having gh with the area being swollen, atoma and tender to touch to the hospital at 10:50 a.m. from the emergency room, at 11:07 a.m. identified R9's ened and externally rotated. A lat 13:06 (1:06 p.m.) from the energy shad contacted and sustained a spiral femur. An admission note lated 8/23/16, at 16:02 (4:02 lad a severe right femur indicated can see femur close constrated non-verbal and had a very swollen right 8/23/16, at 11:01 a.m. nursing ted she did not get R9 up that and night shift got R9 up. NA-H ansferred R9 to the wheel chair a full body lift rather than the sore on the right side. 8/23/16, at 2:25 p.m. NA-J	F 1	57			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIEF			10	REET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTH HILL STREET A CRESCENT, MN 55947		
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F 157	the instructions to indicated on the N carry with them. During interview o stated she was we 8/22/16. NA-D state up out of her reclir leaning way to the the left side, which stated R9 could no pain. NA-D state nurse immediately went in to put R9 t again attempted to not put any weight pale and weak. Nabody lift to get R9 again told the nurse nurse then went to signs (VS). During interview o assistant director of when R9 was unal going from an EZ situation should have warranted further stated, "This would condition for R9." During interview o stated she was tracommode to the b transfer belt. During caught on the comturn to get the residence of the state of the residence of the part of the pa	age 4 an EZ stand lift. NA-J stated use the EZ stand lift were A care sheet that the aides on 8/23/16, at 2:32 p.m., NA-D orking the evening shift on ated when she went to get R9 her with the EZ lift, R9 was left putting all of her weight on a was not usual for R9. NA-D of stand and was wincing with d at that time she notified the an NA-D stated that when she to bed later that evening she of use the EZ lift and R9 would and ne right leg and was very A-D stated staff then used a full into bed. NA-D stated she se of R9's condition and the of check on R9 and took vital on 8/24/16, at 11:21 a.m. the of nursing (ADON) stated that be to transfer her typical way, lift to a full body lift, the ave been looked into and investigation. The ADON d be considered a change of the R9/21/16 and utilized a light transfer R9 got her heel and and when NA-H went to dent onto the bed, R9 fell into R9 to the floor. NA-H stated	F 1	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245319	B. WING _		08	/26/2016	
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947	•	, = 0 : 0	
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F 157	During interview on registered nurse (F the day shift on 8/2 approximately 10:0 having trouble keep RN-C stated that NR9 was moaning at complaining of her on 8/24/16, at 2:55 worked the evening was told in report the during the day. RN safe transferring RS stated staff asked he did and she took R further stated R9 who be in a lot of pain who bed. RN-A also stanotice R9's right leg noted the "huge" he "huge" scrape on he facial grimaces who stating, "She was who pain.". RN-A stated one leg was shorted documented and refindings. During interview on stated she had wor NA-K stated it was R9 had an incident stated R9's leg was asked for a pain me stated when she we with the EZ lift, R9	ht leg and complained of pain. 18/24/16, at 3:32 p.m. 18/16. RN-C stated that at 0 a.m. an aide told her R9 was bing her feet on the EZ lift. 18/16. A-A had reported to her that and groaning a lot and leg hurting. During interview p.m. RN-A stated she had gof 8/22/16. RN-A stated she hat R9 was transferring poorly leasted the aides didn't feel with the EZ stand lift. RN-A her to go look at R9 which she gy's v.s. which were fine. RN-A was grimacing and appeared to when she was assisted into ated, at around 10:00 p.m. she gwas "out of sync" and she ematoma on R9's thigh and the er side. RN-A stated R9 had le staff were turning her eaker and having a lot of she did not check to see if a than the other but exported off to the night shift her la 8/25/16, at 6:27 a.m. NA-K ked the night of the 8/21/16. NA-K is swollen and sore and R9 ed during the night. NA-K ent to get R9 up in the morning was crying and moaning in transfer NA-K stated the	F 18	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 157	stated she was goi morning. NA-K state complained of pain could not bear weig stated,"Her leg hur put pressure on it, During interview or stated she worked complained of pain NA-L also stated R with movement and her she grimaced During interview or stated she had woo NA-A stated R9 was would not open her called which would stated she used the care plan indicated pain with the transformal, was not trarepeating she had During interview or stated she was on the floor. LPN-B sibruising, did a little think the right leg at During interview or stated R9 was hav 8/22/16. RN-D stated pain in the right low will have pain after	gave R9 a pain medication and ng to look at R9's leg in the ated when she sat R9 up R9 and started moaning and ght on her right leg. NA-K t really bad and she wouldn't it was swollen at that time." 18/25/16, at 6:40 a.m. NA-L Monday (8/22/16) and R9 when she was rolled over. 9's leg was swollen and painfuld stated, "Anytime we rolled and complained of pain." 18/25/16, at 9:37 a.m. NA-A rked the day shift 8/22/16. It is very restless and tired and reyes when her name was be unusual for R9. NA-A e EZ stand as that is what the I. NA-A stated R9 had a lot of fers which was reported to the IR9 was different than her ansferring well and kept	F 15	57				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	OMPLETED
245319 B. WING	08/26/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 Continued From page 7 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. RN-D stated she gave R9 Tylenol in the morning before she got up. During interview with the ADON on 8/24/16, at 11: 21 a.m. the ADON verified the physician should have been notified sooner of R9's increased pain and inability to transfer. The ADON verified the documentation identified R9 had been demonstrating pain, had swelling of her leg, and was restless from 8/21/16 to 8/23/16. R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet. R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity, non pressure, initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy. Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/	26/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		101 S	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH HILL STREET RESCENT, MN 55947			
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F 157	nurse (RN)-A dated included the following arm from shoulder resident denies paint full lift for transfers both bladder and state measurements of the evidence of notification nursing staff. A substance by RN-A dated included: "Did requivaled (hour of sleep) for leffective." Further review of Fino further mention progress note dated The progress note dated The progress note Change of Condition CNAs (certified nurell (large) dk. (dark) pure aspect of L (left) upshoulder to L elbow on lateral L thoracion body that appear to on admission assess. There is a brief not dated 8/10/16 @ (abruise from shoulded Background: Last for 7/29/16. Res. is on mouth) daily for MI prevention, has not anticoagulation the Living Center) since	_	F 1	57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/	26/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947			E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 157	does not include play pathology. Noted to confusion on 8/16/10 old). Assessment: upper arm, 28 cm (cm W (wide) is dk. thoracic 8 cm L x 1 soft. No palpable fi This writer is unable chart re: a CBC (co count result. Resportent Problem (licensed) nursing and charting. This issue to Dr. [physic writer is not certain occurrence due to the General Note/Progreare). When interviewed a stated when a new identified the charg resident and initiate background, assess The nurse would the a temporary care pleaning in condition RN-A stated a bruis suspicious, would be further stated if bruis or if a larger bruise origin was identified also be reported to the 8/10/16 progress pertaining to R38's confirmed the resident.	ge 9 n). Medical hx (history) list atelet or blood clotting factors have increased mental 6. Elderly male 96 y.o. (years measurements - posterior L centimeters) L (long) x (by) 12 purple and soft. Lateral L 0 cm W is a lighter purple, rm areas on either location. The to find a lab report in paper mplete blood count) or platelet onse: This writer initiated a for communication to lic staff for on-going assessment writer will fax a note re: this ian name] at local clinic. This that bruising is new he notation in the 8/10/16 ress Notes in PCC (point click on 8/24/16, at 4:16 p.m. RN-A skin condition for a resident is e nurse would assess the ean SBAR (situation, sment, recommendation) note. In notify the physician, create an, and pass on the resident's in report to the next shift. The effort of the state. RN-A ising was occurring frequently or hematoma of unknown and and not explainable it would the state. Surveyor reviewed as note written by RN-A left arm bruising. RN-A ent had large bruising to the extended from the shoulder to	F 1	57				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245319	B. WING		08/	26/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
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F 157	of bruising but then bruising was unusu stated she should hand notified the phy not been done. RN had not been passe investigated for post the state agency whon 8/10/16. When interviewed of director of nursing (issue was identified the source of the sk complete an SBAR to the temporary prinext shift. Nursing let the charge nurse identify a new skin measured though numeasure again, but the bruising was gewere measured we unless there was a further stated if a la unknown origin was expect it to be repo DON stated she was bruising first identifications as to admission to the many bruises upon R38's medical recowas not admitted we confirmed the large origin to R38's left as	ated the resident had a history verified that amount of all for the resident. RN-A have completed an SBAR note resician and confirmed that had resident and confirmed that had resident and confirmed the bruising and on to the next shift, asible causes nor reported to men the bruising was identified and 8/26/16, at 8:46 a.m. the DON) stated when a new sking the nurse should investigate and the nurse should investigate and the skin issue oblem list to pass on to the assistants (NA's) are also to be known as soon as they concern. Bruises are initially the ursing wouldn't necessarily would monitor and indicate if the state of anot explainable, she would red immediately to the state. Its unaware of R38's left arm	F 1	57		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/:	26/2016	
	PROVIDER OR SUPPLIER	A CRESCENT		101 9	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH HILL STREET CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 157	agency when first ic	ige 11 sician, administrator, and state dentified on 8/10/16, and tigated and monitored by	F 1	57				
F 225 SS=D	Resident Health Staincluded: The cent physician, nurse prassistant, and if known representative or any when there is: (A)	PORT	F 2	25			9/23/16	
	been found guilty o mistreating residen had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for	ot employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or the State nurse aide registry ties.						
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in	isure that all alleged violations lent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency).						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION (3	(X3) DATE SURVEY COMPLETED		
		245319	B. WING		08/26/2016	
	PROVIDER OR SUPPLIER	A CRESCENT	1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET A CRESCENT, MN 55947	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 225	violations are thoroprevent further pote investigation is in p The results of all into the administrator representative and with State law (inclicertification agency incident, and if the	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 225			
	by: Based on interview facility failed to reprabuse/neglect imm State agency for 1 sustained a spiral f direct result of the and for 1 of 1 resid bruising of unknow Findings include: R9's admission recincluding dementia current pathological R9's Minimum Data assessment dated Interview for Menta severe cognitive im Assessment (CAA)	ediately to the designated of 3 residents (R9) who racture of the right femur as a care plan not being followed, ent (R38) with significant n origin.		1. Facility has reported to state ager allegation of abuse/neglect for R9. F has reported to state agency bruise ounknown source for R38. 2. All residents had the potential to be affected by failure to report allegation immediately to the designated state agency. 3. Facility staff have been educated reporting allegations of abuse to designated state agency. 4. DNS or designee will complete rail audits of incidents for possible allegations of abuse and timely reporting to designated state agency weekly for fewer weeks and monthly for two months. Results will be communicated to facility of the state agency weekly for fewer and timely reporting to designated state agency weekly for fewer and monthly for two months. Results will be communicated to facility and the state agency weekly for fewer and monthly for two months.	acility of e ns on ndom ation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245319	B. WING _		08	/26/2016	
	PROVIDER OR SUPPLIER	A CRESCENT	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947				
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F 225	identified R9 had p ADL (activities of da interventions that in transfer assist of or 2 staff as needed (interdisciplinary residentified ADL's incistand lift. The certicare sheet, update required the EZ statransfers. Review of R9's nur 9:54 p.m. identified from the commode and slid down on the incident report date (interdisciplinary terecommendations, w/ (with) EZ stand time of fall. Educat assistant (NA) assistand for transfers. notes identified R9 8/23/16 with a spiral During interview on stated she transfer was lowered to the was transferring R9 bed R9's right heel she was turning he slid her to the floor. supposed to use th NA-H stated she use	ff with transfers. e plan revised 3/25/16, hysical functioning ally living) deficit with neluded R9 should have ne staff and EZ stand lift or use PRN). Review of the quarterly ident review dated 8/15/16, luded transfers with the use of fied nursing assistant (NA) d 8/23/16, identified R9 and and 1 staff assist for sing notes dated 8/21/16, at R9 was being transferred to the bed with a transfer belt are floor next to her bed. The are d 8/21/16, under the IDT	F 22	5			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		E SURVEY PLETED
		245319	B. WING			08/2	26/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	the EZ stand was s when transferring. I by not using it." W special reason she the stand NA-H stathey were short stated. During interview with (DON) on 8/23/16, NA-H had not followansfers and that in the State agency undersed practical indicated practical indicated stated she'd the R9 with the belt sin NA-H then stated F the commode when had fallen towards. R9's medical record an incident report incident occurred, at the hospital and dia The incident report indicated the report reported was negle R38 was admitted to diagnoses including failure, atrial fibrillatins ufficiency, and madmission record far R38's 14-day admission record far R38's 14-day admission from the standard record far R38's 14-day admission re	also stated she was aware upposed to be used for R9 NA-H stated "I screwed up big then asked if there was any used the transfer belt and not ted both lifts were in use and ffed. In the director of nursing at 3:12 p.m. the DON verified wed R9's care plan for to report had been filed with intil today (8/23/16). 8/25/16, at 11:53 a.m. urse (LPN)-B verified NA-H are plan. LPN-B said NA-H ought she could just transfer ce R9 was right by the bed. R9's foot had gotten caught on a she was turning her and R9 NA-H. In didocuments lacked evidence ad been submitted to the R9/23/16, 2 days after the and after R9 had been sent to agnosed with a spiral fracture. Submitted on 8/23/16 of maltreatment being ct. To the facility on 7/19/16 with gunspecified fall, acute kidney inon, chronic peripheral venous hacular degeneration per the	F 2	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 225	impairment. The Norequired total assist bathing, and extension mobility, locomotion use, and personal lincluded a focus of pressure, initiated a Conduct weekly sk signs and symptom swelling, redness, aphysician of significant assessment to be a Policy. Review of the nursing from shoulder resident denies painfull lift for transfers both bladder and significant measurements of the evidence of notificant nursing staff. A sulfinote documented by (11:13 p.m.) including the eded) Oxycodom upper arm pain, that Further review of Further was no menting progress in (2:42 a.m.). The progress of (1:00 a.m.) CNAs (discovered lg. (largarea on posterior and person to the edecomposition of the progress of (1:00 a.m.) CNAs (discovered lg. (largarea on posterior and person of the progress of (1:00 a.m.) CNAs (discovered lg. (largarea on posterior and person of the progress of (1:00 a.m.) CNAs (discovered lg. (largarea on posterior and person of the progress of (1:00 a.m.) CNAs (discovered lg. (largarea on posterior and person of the progress of (1:00 a.m.) controlled the progress of (1:00 a.m.) CNAs (discovered lg. (largarea on posterior and person of the progress of (1:00 a.m.) controlled the progress of (1:00 a.m.) control	Ing moderate cognitive MDS further indicated R38 tance with transfers and sive assistance with bed in on/off unit, dressing, toilet hygiene. The care plan altered skin integrity, non B/1/16. Interventions included: in inspection. Monitor for its of infection such as warm, discharge, odor, notify cant findings. Skin completed per Living Center in grogress note by registered its 8/10/16, at 23:25 (11:25 p.m.) ing, "Noted bruising on left to elbow. Area soft and in to touch. Continues to need and remains incontinent of tool." The note did not include the left arm bruising nor attion to the physician or other obsequent nursing progress by RN-A dated 8/14/16 at 23:13 and, "Did request prin (as the eat his (hour of sleep) for left	F 22	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245319	B. WING	i		08/2	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP C 101 SOUTH HILL STREET LA CRESCENT, MN 55947	ODE		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 225	res.'s (resident's) b were not present or paper form 7/19/16 Gen. (general) Notice: a L upper arm be no measurement. This facility is on 7/2 325 mg p.o. (by moinfarction) prevention injectable anticoage (Golden Living Centrecent admission however, or clotting factors path increased mental complete season of the firm areas on either to find a lab report (complete blood con Response: This will problem for commonursing staff for one charting. This write to Dr. [physician nais not certain that be to the notation in the Note/Progress Note (Peview of the Verificated 8/18/16, commondirector (ED) include "Description of every common of the propose of the Verificated 8/18/16, commondirector (ED) include "Description of every control of the paper of the Verificated 8/18/16, commondirector (ED) include "Description of every control of the paper of the Verificated 8/18/16, commondirector (ED) include "Description of every control of the paper of the Verificated 8/18/16, commondirector (ED) include "Description of every control of the paper of the verificated 8/18/16, commondirector (ED) include "Description of every control of the paper of the verificated 8/18/16, commondirector (ED) include "Description of every control of the paper of the verificated and t	a on lateral L thoracic area of ody that appear to be new and a admission assessment. There is a brief notation in a edated 8/10/16 @ (at) 2325 truise from shoulder to elbow, Background: Last fall here at 29/16. Res. is on ASA (aspirin) buth) daily for MI (myocardial on, has not be on p.o. or culation therapy here at GLC oter) since admission. Most ere has [sic] for post hip fx ehabilitation). Medical hx oot include platelet or blood hology. Noted to have onfusion on 8/16/16. Elderly old). Assessment: esterior L upper arm, 28 cm ang) x (by) 12 cm W (wide) is a Lateral L thoracic 8 cm L x for purple, soft. No palpable or location. This writer is unable in paper chart re: a CBC cunt) or platelet count result. Friter initiated a Temporary cunication to lic (licensed) and gassessment and the rewill fax a note re: this issue the medical and controlled in the control of the controlled	F 2	225			

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	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947		
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F 225	outer torso likely of use for transfers. A nursing indicates by SBAR was complet notification complet Assessment of Resonated resident presupper arm from showas unknown. SBANOC (night) nurse bruising as well as torso region. Bruismore swollen than open skin found on facility was 7/29/16 Resident interview pan to bruised area cause of bruising a until notified by staf Casual/contributing Resident had a fall is chronically on AS anticoagulation for dependent with all the mechanical lift use Resident noted to hond to CNAs during AD transfers r/t (related anticoagulation mechanical skin Recommendation/in reoccurrence: More to CNAs during AD transfers r/t (related anticoagulation mechanical skin Recommendation mechanical skin Recommendatio	de bruising to left arm and left courred from mechanical lift a progress note 8/10 by ruising first noted then. An red 8/17 with family and MD red at that time. Sident: on 8/10 it was first ented with new bruising to left bulder down to elbow, cause AR report was completed by 8/17 in relation to left arm extended bruising to left outer res are dark purple. Left arm is the right. No hematoma or assessment. Last fall in summary: Resident denies as. Resident is unable to recall and was unaware of bruising f. factors and observations: on 7/29 from bed to floor. He as 325 mg as only MI prevention. Resident is transfers which requires and 1-2 person assist. The progression which is being the careful handling reinforced and mechanical lift at to) fragile skin and	F:	225			

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F 225	Resident was evaluated took place on 8/17 medication changes ordered by MD. " When interviewed of stated when a new identified the chargeresident and initiate background, assess. The nurse would the atemporary care pleased in condition RN-A stated a bruis suspicious, would be further stated if brui or if a larger bruise origin was identified also be reported to the 8/10/16 progress pertaining to R38's confirmed the residuleft upper arm that the elbow. RN-A stof bruising but verif was unusual for the should have compleased or for possible causes agency when identified the physicial been done. RN-A for the state of the physicial been done. RN-A for the state of the physicial been done. RN-A for the state of the physicial been done. RN-A for the state of the physicial been done. RN-A for the physicial been done in the physicial been done.	my event was from my self transfer on 7/29. The self transfer of the self transfer of the self transfer of transfe	F 2				

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F 225	to the temporary property shift. Nursing let the charge nursidentify a new skin measured though resource again, but the bruising was gowere measured we unless there was a further stated if a launknown origin was expect it to be reported to bruising first identifications at the subsequently on 8/prone to bruising a to admission to the many bruises upon R38's medical recowas not admitted woonfirmed the large origin to R38's left assessed with common reported to the phy agency when first is subsequently investigation. When interviewed ED stated after investigations and some stated after investigation.	age 19 It note, and add the skin issue roblem list to pass on to the assistants (NA's) are also to the expectation of the assistants (NA's) are also to the expectation of the expectati	F 22	25			
	resident. The ED of report the significant the State agency p the possible source ED was unaware if	full body lift used for this confirmed the facility did not not bruising of unknown origin to rior too or after investigating to of the bruising. Further, the staff had been observed using aining provided following the					

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F 225 F 226 SS=D	investigation into the 483.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negli	ne bruising. DP/IMPLMENT T, ETC POLICIES Evelop and implement written	F 22			9/23/16
	by: Based on interview facility failed to imp the immediate reportance administrator and the for 1 of 3 residents fracture of the right care plan not being (R39) with signification addition, the polity would constitute minjuries of unknown resident's property. Findings include: The policy titled, Realleged Violations of Unknown Source Resident's Property following: It is the appropriate steps the appropriation of the interview of Unknown Source Resident's Property following: It is the appropriate steps the appropriation of the interview of th	NT is not met as evidenced and document review, the element their policy related to orting of abuse/neglect to the he designated State agency (R9) who sustained a spiral efemur as a direct result of the followed, and 1 of 1 resident and bruising of unknown origin. Cy did not clearly define what istreatment, abuse, neglect, a source or misappropriation of the federal and State Laws and Misappropriation of y dated 7/12/16, included the policy of the Company to take to prevent the occurrence of uries of unknown origin and for resident property and to ged violations of Federal or		1. Administrator has been notifie alleged violations and will report rinvestigation to state agencies as required. 2. All residents had the potential affected. 3. Facility staff have been educat newly updated policy (updated 9/which includes examples of abus time lines on appropriate reportin alleged violations to administrator notification of state agencies. 4. DNS or designee will complete audits of notification of administra alleged violations and reporting to agencies for four weeks then more two months. Results will be communicated to facility QAPI communicated.	esults of to be ed on 7/16) e and g for r and r random ator of o state nthly for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
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F 226	State laws which in abuse, injuries of un misappropriation of violations"), are rep Executive Director of And the Director of Aegis employee. So reported to State age existing State law. Investigation of each there is a conflict of implicated in the all responsible to repoinvestigations to the by state and federa. The policy further in Reporting of susper required of every endinged violation, under the policy included: An alleged violation should be a policy in accordant of the policy in accordant investigations must appropriate State a law, within five (5) with a policy did not constitute mistreatmon of unknown source resident's property.	volve mistreatment, neglect, nknown origin and resident property ("alleged orted immediately to the (hereinafter "ED") of the center f Rehabilitation (DOR) if it is uch violations will also be gencies in accordance with The ED will direct a thorough h such alleged violation unless interest or the ED is eged violation, The ED is rt the results of all e state agencies as required I law.	F 2	226			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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_	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	current pathologica R9's Minimum Data assessment dated Interview for Menta severe cognitive im Assessment (CAA) and fall related injur assistance of 2 stat Review of R9's care identified R9 had pl ADL(activities of da interventions that in transfer assist of or 2 staff as needed (I interdisciplinary res identified ADL's inc stand lift. The certi care sheet, updated required the EZ stat transfers. Review of R9's nurs 9:54 p.m. identified from the commode and slid down on th incident report date (interdisciplinary tea recommendations, w/ (with) EZ stand f time of fall. Educat R9. R9 will remain Further review of th transferred to hosp fracture of the right During interview on	I fracture. a Set (MDS) significant change 5/18/16, identified a Brief I Status score of 00 indicating pairment. The Care Area identified R9 at risk for falls ries and the need for extensive if with transfers. be plan revised 3/25/16, hysical functioning illy living) deficit with icluded R9 should have be staff and EZ stand lift or use PRN). Review of the quarterly ident review dated 8/15/16, huded transfers with the use of fied nursing assistant (NA) deficit R9 and 1 staff assist for sing notes dated 8/21/16, at R9 was being transferred to the bed with a transfer belt of the bed with a spiral belt all 8/23/16 with a spiral	F 2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245319	B. WING _		08	/26/2016	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	8/21/16 when R9 w stated while she w the commode and the commode as s "Fell into me and I stated staff were s lift to transfer R9. transfer belt at tim commode or whee stated she was aw supposed to be us NA-H stated "I scr When asked if the used the transfer is stated both lifts we staffed. During interview w (DON) on 8/23/16 NA-H did not follo and that no report agency until 8/23/10 During interview o licensed practical did not follow the othought she could since R9 was right R9's foot got caug was turning her ar NA-H. R9's medical reco an incident report agency until 8/23/10 occurred, and R9 diagnosed with a sreport submitted or state of the s	was lowered to the floor. NA-H as transferring R9 between bed R9's right heel caught on the was turning her and R9, slid her to the floor." NA-H upposed to use the EZ stand NA-H stated she used the es to transfer R59 between the elchair and the bed. NA-H also ware the EZ stand was used for R9 when transferring. Ewed up big by not using it." re was any special reason she could be and they were short with the director of nursing at 3:12 p.m. the DON verified w R9's care plan for transfers had been filed with the state	F 22	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/:	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		101 SC	T ADDRESS, CITY, STATE, ZIP CODE OUTH HILL STREET RESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	diagnoses including failure, atrial fibrillat insufficiency, and madmission record fall R38's 14-day admission record fall R38's 14-day admission record fall R38's 14-day admission a brief interview for 12 indicating model. The MDS further in assistance with trarextensive assistance locomotion on/off upersonal hygiene. Of altered skin integ 8/1/16. Intervention skin inspection. Modern of infection such as discharge, odor, not findings. Skin asset Living Center Policy. Review of the nursinurse (RN)-A dated included the following arm from shoulder resident denies painfull lift for transfers both bladder and stame asurements of the evidence of notificanursing staff. A submote by RN-A dated included: "Did requer (hour of sleep) for leffective."	o the facility on 7/19/16 with gunspecified fall, acute kidney ion, chronic peripheral venous nacular degeneration per the ace sheet. ssion data set (MDS) included mental status (BIMS) score of rate cognitive impairment. dicated R38 required total asfers and bathing, and se with bed mobility, nit, dressing, toilet use, and The care plan included a focus prity non pressure initiated as included: Conduct weekly onitor for signs and symptoms swelling, redness, warm, tify physician of significant assment to be completed per	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/2	6/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP COE 101 SOUTH HILL STREET LA CRESCENT, MN 55947)E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			(X5) COMPLETION DATE
F 226	The progress note Change of Condition CNAs (certified nur (large) dk. (dark) paspect of L (left) upshoulder to L elbow on lateral L thoracide body that appear to on admission asse There is a brief not dated 8/10/16 @ (abruise from should Background: Last f7/29/16. Res. is or mouth) daily for MI prevention, has not anticoagulation the Living Center) since admission here has rehab. (rehabilitation does not include pleathology. Noted to confusion on 8/16/10/16). Assessment: upper arm, 28 cm (cm W (wide) is dk. thoracic 8 cm L x 1 soft. No palpable f This writer is unable chart re: a CBC (cocount result. Responder Temporary Problem (licensed) nursing and charting. This issue to Dr. [physic writer is not certain occurrence due to continue to the continue of the continue to the count result.	age 25 d 8/17/16 at 02:42 (2:42 a.m.). indicated: Type: SBAR - on Situation: 0100 (1:00 a.m.) rsing assistants) discovered lg. urple bruised area on posterior oper arm extending from L or and a smaller bruised area of res.'s (resident's) of be new and were not present assment paper form 7/19/16. The ation in a Gen. (general) Note at 2325 re: a L upper arm for the elbow, no measurement. The all here at this facility is on the ASA (aspirin) 325 mg p.o. (by (myocardial infarction) at be on p.o. or injectable rapy her at GLC (Golden elbo admission. Most recent at all for post hip fx (fracture) on). Medical hx (history) list at at the or blood clotting factors on have increased mental at the first of th	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
245319			B. WING		08	08/26/2016	
	ROVIDER OR SUPPLIER LIVINGCENTER - LA	CRESCENT	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	dated 8/18/16, com director (ED) included Description of even occurred from an undome) staff concluded outer torso likely occurred from an undome) staff concluded outer torso likely occurred from an under torso likely occurred from sing indicates by SBAR was completed to the completed from the completed from the control of the concept of the concept of the concept of the confusion of the confus	cation of Investigation report pleted by the executive led the following: t/allegation: Bruising has nknown cause. NH (nursing de bruising to left arm and left curred from mechanical lift A progress note 8/10 by ruising first noted then. An red 8/17 with family and MD red at that time. Sident: on 8/10 it was first bented with new bruising to left bruider down to elbow, cause AR report was completed by 8/17 in relation to left arm extended bruising to left outer res are dark purple. Left arm is the right. No hematoma or assessment. Last fall in summary: Resident denies as. Resident is unable to recall and was unaware of bruising f. factors and observations: on 7/29 from bed to floor. He 6A 325 mg as only MI prevention. Resident is transfers which requires and 1-2 person assist. The resident is transfers which is being umented by nursing. Resident	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD I	BE	(X5) COMPLETION DATE
F 226	transfers r/t (related anticoagulation med Summary and outed Nursing, resident are exact time, location bruising took place, an event. Only kno documented fall fro Resident was evaluted took place on 8/17 medication changes ordered by MD. When interviewed of stated when a new identified the chargeresident and initiate background, assess The nurse would that a temporary care place than the chargeresident and initiate background, assess the nurse would that a temporary care place in condition RN-A stated a bruis suspicious, would be further stated if brui or if a larger bruise origin was identified also be reported to the 8/10/16 progress pertaining to R38's confirmed the residuleft upper arm that of the elbow. RN-A stof bruising but verified was unusual for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done. RN-A for the should have complemotified the physicial been done.	Ls and mechanical lift I to) fragile skin and dicine. The of investigative findings: and family unable to determine or occurrence in which There were no witnesses to	F 2	226			

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION		COMPLETED			
		245319	B. WING _	B. WING		26/2016
	PROVIDER OR SUPPLIER	CRESCENT	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(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 APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	for possible causes agency when identi When interviewed of director of nursing (issue is identified the source of the skin is complete an SBAR to the temporary property of the charge nurse identify a new skin of a large or suspicious was not explainable reported immediate the large area of brown of an SI physician, administifirst identified on 8/ When interviewed of ED stated after investigant from the firesident. ED confirms the significant bruis State agency prior to possible source of the significant state agency prior to possible source of the significant state.	nor reported to the State fied on 8/10/16. on 8/26/16, at 8:46 a.m. the DON) stated when a new skin he nurse should investigate the ssue, notify the physician, note, and add the skin issue oblem list to pass on to the assistants (NA's) are also to be known as soon as they concern. DON further stated if it is bruise of unknown origin to be she would expect it to be say to the state. DON confirmed uising of unknown origin to be left to the state. DON confirmed uising of unknown origin to be left to the state agency when 10/16. on 8/26/16, at 9:04 a.m. the estigating R38's left upper arm uising deemed that it was all body lift used for this med the facility did not report ing of unknown origin to the too or after investigating the the bruising. Further, the ED off had been observed using aining provided following the	F 23	26		
F 282 SS=G	483.20(k)(3)(ii) SEF PERSONS/PER CA The services provided b	RVICES BY QUALIFIED	F 28	32		9/23/16
		·				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245319	B. WING		08/26/2016	
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) DMPLETION DATE
F 282	care.	nge 29 NT is not met as evidenced	F 282			
	by: Based on observareview, the facility frelated to transfers R14) that resulted i resident was lowerd spiral femur fractur follow the care pland (ADL's) for 1 of 3 remonitor bruising for reviewed for bruise. Findings include: R9 was admitted or admission record in dementia and oster pathological fractur. R9's Minimum Data assessment dated Interview for Menta severe cognitive im Assessment (CAA) and fall related injurassistance of 2 staridentified R9 had processing the facility of the fa	tion, interview and document ailed to follow the care plan for 2 of 3 residents (R9 & n actual harm for R9 when the ed to the floor and sustained a e. The facility also failed to a for activities of daily living esidents (R12), and failed to a for 1 of 1 resident (R38) s of unknown origin. In 11/11/13. Review of R9's dentified diagnoses including opporosis without a current e. A Set (MDS) significant change 5/18/16, identified a Brief I Status score of 00 indicating apairment. The Care Area identified R9 at risk for falls ries and the need for extensive ff with transfers.		1. Comprehensive care plan for re R9, R14, R12 and R38 have been reviewed and revised to reflect resicurrent care needs. 2. All residents had potential to be affected. 3. Nursing staff have been educate following care plan and CNA care swhen providing resident care and monitoring bruising and nail care. 4. DNS or designee will complete raudits of following care plans/care especially in regards to transferring nail care and also monitoring of bruweekly for four weeks then monthly two months. Results will be communicated to facility QAPI communicated.	dents d on sheets andom sheets and and sheets and grand gr	
	assist of one staff a as needed (PRN). interdisciplinary res	lude R9 should have transfer and EZ stand lift or use 2 staff Review of the quarterly ident review dated 8/15/16, luded transfers with the use of				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION G		TE SURVEY MPLETED	
	245319		B. WING		08/26/2016		
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(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) COMPLETION DATE	
F 282	care sheet, updated required the EZ stat transfers. Review of R9's nursy: 9:54 p.m. identified from the commode and slid down on the incident report date (interdisciplinary tearecommendations, intervention of 1 as transfers was not for Education was proved R9 would remain as Further review of the transferred to the horacture of the right. During interview on assistant (NA)-H stated while she was the commode and I stated staff were suffit to transfer R9. It transfer belt at time commode or wheel stated she was aways.	fied nursing assistant (NA) d 8/23/16, identified R9 and and 1 staff assist for sing notes dated 8/21/16, at R9 was being transferred to the bed with a transfer belt be floor next to her bed. The d 8/21/16, under the IDT am) review and identified the care plan sist w/ (with) EZ stand for bllowed at the time of the fall. wided to the NA assisting R9. In EZ stand for transfers. In enurses notes identified R9 ospital 8/23/16 with a spiral	F 28.	,			
	When asked if ther used the transfer be	ewed up big by not using it." e was any special reason she elt and not the stand NA-H she re in use and they were					

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	PROVIDER OR SUPPLIER	A CRESCENT		1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 282	During interview wi (DON) on 8/23/16, NA-H did not follow the conticensed practical right did not follow the contought she could justice R9 was right R9's foot got caugh was turning her and NA-H. On 8/23/16, at 8:35 transferred with a file 8/23/16, at 9:30 a.r pain in her right this having a large hem and movement. R9 was transferred on 8/23/16. A note (ER) visit dated 8/2 R9's right leg was a rotated. A note from the ER identificant contacted the faciliant a spiral fracture of note from the hosp (4:02 p.m.) identifier fracture. The note is to skin and R9 demindicators of pain a femur/hip area. During observation p.m. R12 was observati	th the director of nursing at 3:12 p.m., the DON verified w R9's care plan for transfers. 18/25/16, at 11:53 a.m. hurse (LPN)-B verified NA- Hare plan. NA-H stated she ust transfer R9 with the belt by the bed. NA-H then stated at on the commode when she d R9 fell in a direction towards a.m. a note identified R9 was full body lift. A note from in. identified R9 was having gh with the area being swollen, atoma and tender to touch at the theorem of the t	F 2	282				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
245319			B. WING			08/26/2016	
	PROVIDER OR SUPPLIER	CRESCENT		1	OTREET ADDRESS, CITY, STATE, ZIP CODE O1 SOUTH HILL STREET A CRESCENT, MN 55947	1 00//	20/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	nails were long and to have her nails cu 8/24/16, at 10:25 a. bed. During the obscontinue to have lowere soiled undern have a black/brown cuticle. R12 was in observation and stanails cut and that stanails rer with the black/brow left thumb. R12 staroom to cut her nail they would. On 8/2 observed in her roof jagged and dirty wit still present on the	ge 32 I soiled and stated she needed at as they were too long. On m. R12 was observed lying in servation R12 was noted to ng, jagged fingernails that eath. R12 was further noted a substance on her left thumb sterviewed during the ated she needed to have her taff were going to do it ne day. On 8/24/16, at 4:00 mained long, jagged and dirty in substance remaining on the ated, staff had not come to her is and she wasn't sure when 15/16, at 7:31 a.m. R12 was of with nails remaining long, the black/.brown substance left thumb cuticle. R12 also are too long and she needed	F 2	282			
	assessment dated Interview for Menta score of 11 indicatin impairment. The M required extensive hygiene.	imum data set (MDS) 8/10/16, included a Brief I Status (BIMS) assessment ng moderate cognitive IDS also identified that R12 assistance with personal rrent resident care sheet					
	identified R12 receil Friday mornings and that was to be remoted R12's bath scheduled had received a bath identified staff were DO NAIL CARE!! T	ved a weekly bed bath on d had a splint to the left hand oved daily for hygiene. Review dule for 8/19/16, indicated R12 h. The bath schedule to PLEASE REMEMBER TO he care plan revised 8/24/16, ired assistance of one staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	,		
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F 282	(PRN). R12 also h palm guard in the A hand hygiene which review report dated. When interviewed nursing assistant (I bath on Fridays and her nails. She stated not get done becaut instead of a tub ballike R12's nail care bed bath on Friday were long, jagged a would clean and tri NA-B also stated, "to do nails with a balways do it." When interviewed DON confirmed R1 for nail care. Review of the faciliareviewed 12/7/15, in PROCEDURE: 14. toenails is part of the clean. R14 was admitted dementia, chronic (COPD), depression per the admission of the quarterly Minimassessment dated required extensive	ene and nail care as needed and an order to remove her A.M. with cares and complete h was indicated on the order d 8/1/16-8/31/16. on 8/25/16, at 10:58 a.m. NA)-A stated R12 got a bed d staff were supposed to do ed at times the nail cares did use she received a bed bath th. NA-A verified it did not look had been completed with her. NA-B verified R12's nails and dirty. NA-B stated she m R12's nails right away. It tell my director that they need ed bath too and they don't on 8/25/16, at 11:00 a.m. the 2's care plan was not followed ty policy for Bed bath, last ncluded: Care of fingernails and ne bath. Be certain nails are	F2	282				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245319	B. WING	B. WING			08/26/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	,		
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F 282	with one person phemobility, transfer, a R14's care plan las risk for falls. Interv W/C (wheelchair) a daily for proper fund nursing assistant as utilized a bed and of the working assistant (Nassistance with transferse cares as she be disturbed. NA-E utilized an alarm who when interviewed and stated that when Parefuse cares as she be disturbed. NA-E utilized an alarm who working assistance with transferse cares as she be disturbed. NA-E utilized an alarm who working with her leg of the bed. R14's who work to the bed by the wall with her leg of the bed. R14's who work in the bed or chair 10:05 a.m., NA-A stransferred herself alarm was not in plasmad should have be working on the resistence working on the resistence of the past. NA-A searched R14 unable to locate on had been known to in the past. NA-A a resident in bed but	ysical assistance with bed and locomotion off the unit. It revised 4/4/16, indicated a sentions included: "Bed and larms in place and checked ctioning." Review of the ssignment sheet identified R14 hair alarm for safety. In 8/24/16, at 3:20 p.m. INA)-D stated R14 required ansfers and toileting though sk staff for assistance. NA-D 14 is in bed, she would often by was unsure if the resident	F 2	282				

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/:	26/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		101 SO	FADDRESS, CITY, STATE, ZIP CODE OUTH HILL STREET DESCENT, MN 55947	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	positioned R14's was brakes locked then assistant director of was in need of a bette ADON and NAsensor pad alarm. R14 in bed while the pad underneath the able to place the seresident though R1 repositioning. NA-Frefused morning cawho had assisted the day; NA-B was unsalarm earlier. NA-Ewas unable to locat confirmed the reside	ge 35 (c next to the bed with the exited the room to alert the f nursing (ADON) that R14 and alarm. Shortly afterwards B entered R14's room with a NA-B attempted to reposition a ADON placed the sensor a resident. The ADON was ensor alarm underneath the 4 continued to refuse B stated the resident had ares earlier though was unsure the resident in getting up for the ure if R14 had utilized an B searched R14's room and the an alarm. The ADON ent was to utilize an alarm d in bed per the plan of care.	F2	82				
	diagnoses including failure, atrial fibrillat insufficiency, and madmission record fatter admission record fatter a brief interview for 12 indicating mode. The MDS further in dependence with trextensive assistance locomotion on/off upersonal hygiene. of altered skin integ 8/1/16. Intervention skin inspection. Mo of infection such as	to the facility on 7/19/16 with gunspecified fall, acute kidney tion, chronic peripheral venous nacular degeneration per the ace sheet. Significant set (MDS) included mental status (BIMS) score of trate cognitive impairment. dicated R38 required total tansfers and bathing, and the with bed mobility, and the care plan included a focus grity non pressure initiated the included: Conduct weekly tonitor for signs and symptoms a swelling, redness, warm, tify physician of significant						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245319	B. WING			08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	findings. Skin asses Living Center Policy Review of the Weel and 8/23/16 indicate reviews did not included the following arm from shoulder resident denies pair full lift for transfers both bladder and stameasurements of the evidence of notifica nursing staff. A sub note by RN-A dated included: "Did require (hour of sleep) for leffective." Further review of R include evidence of progress note dated The progress note dated The progress note included to L elbow on lateral L thoracid body that appear to on admission assess There is a brief noted dated 8/10/16 @ (a bruise from shoulded).	kly Skin Reviews dated 8/9/16 ed: Skin Intact. The skin ude evidence of other skin	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	mouth) daily for MI prevention, has not anticoagulation their Living Center) since admission here has rehab. (rehabilitatio does not include pla pathology. Noted to confusion on 8/16/10 old). Assessment: upper arm, 28 cm (cm W (wide) is dk. thoracic 8 cm L x 10 soft. No palpable fit This writer is unable chart re: a CBC (concount result. Responder (licensed) nursing and charting. This issue to Dr. [physic writer is not certain occurrence due to the General Note/Programe). When interviewed of stated when a new identified the charg resident and initiated.	ge 37 ASA (aspirin) 325 mg p.o. (by (myocardial infarction) be on p.o. or injectable rapy here at GLC (Golden e admission. Most recent is [sic] for post hip fx (fracture) n). Medical hx (history) list atelet or blood clotting factors in have increased mental in the factor of have increased mental in	F	282			
	a temporary care pleased in condition RN-A stated a bruis suspicious, would be further stated if bru	en notify the physician, create lan, and pass on the resident's in report to the next shift. See of unknown origin, if the reported to the state. RN-A ising was occurring frequently or hematoma of unknown					

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY 101 SOUTH HILL STRE LA CRESCENT, MN	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	origin was identified also be reported to the 8/10/16 progres pertaining to R38's confirmed the resid left upper arm that the elbow. RN-A st of bruising but then bruising was unusu stated she should hand notified the phynot been done. RN had not been passe investigated for post the state agency when stated she was bruising first identifications as to admission to the many bruises upon R38's medical recowas not admitted wonfirmed the large origin to R38's left a assessed with compreported to the physwhen first identified	d and not explainable would the state. Surveyor reviewed is note written by RN-A left arm bruising. RN-A ent had large bruising to the extended from the shoulder to ated the resident had a history did verify that this amount of all for the resident. RN-A ave completed an SBAR note resician and confirmed that had an index and confirmed the bruising ed on to the next shift, saible causes nor reported to men identified on 8/10/16. On 8/26/16, at 8:46 a.m. the is unaware of R38's left arm ed on 8/10/16 and 17/16. DON stated R38 was a had fallen many times prior facility and was identified with admission. DON reviewed and confirmed the resident ith the left arm bruising. DON area of bruising of unknown arm should have been pletion of an SBAR note, and sician per the plan of care on 8/10/16.	F 2				
F 309 SS=G	Each resident must provide the necessa or maintain the high mental, and psycho	CARE/SERVICES FOR EING receive and the facility must ary care and services to attain nest practicable physical, isocial well-being, in a comprehensive assessment	F3	บษ			9/23/16
		•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245319	B. WING		08/2	6/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	, 55,-	
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa and plan of care.	nge 39	F 309			
	by: Based on observareview, the facility for provide the necess 3 residents (R9) in sustained a femural actual harm, significated facility failed to provide to 1 of 1 residunknown origin and were coordinated with 1 residents (R28) refindings include: R9's admission recincluding demential current pathological R9 was observed in her room in her with moaning. An interview for significant characteristics and more significant characteristics and more significant characteristics. R9's significant characteristics and more significant characteristics and more significant characteristics. R9's significant characteristics are significant characteristics. R9's significant characteristics.	on 8/22/16, at 5:24 p.m. sitting wheelchair restless and view was attempted about her noaning but R9 was unable to ely to questions. Inge Minimum Data Set (MDS) 5/18/16, identified R9 with a Mental Status (BIMS) score of		1. Pain has been assessed and a in place to manage pain for R9. We skin inspections are in place for R3 Hospice provided contact informati R28 and will inform facility and R28 schedule. 2. All residents had potential to be affected for pain management, we skin inspections. R28 is the only horesident in facility. 3. Licensed nursing staff have been educated on pain management, we skin inspections and coordination whospice for care. 4. DNS or designee will complete raudits on pain management, weekl inspections and hospice communic weekly for four weeks then monthly two months. Results will be communicated to facility QAPI communicated to facility QAPI communicated.	eekly 88. on to 8 of visit ekly ospice n eekly vith andom y skin sation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/2	26/2016	
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, 101 SOUTH HILL STREET LA CRESCENT, MN 55947				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE	
F 309	Review of R9's care identified a physical daily living)/deficit w transfers with assis (mechanical lift) or Review of the quart review dated 8/15/1 assistance including certified nursing assupdated 8/23/16, id stand and 1 assist f During review of the entries were noted: On 8/21/16, at 9:54 change of condition was documented in transferred from the transfer belt and slibbed. The note furth right side and that F on her right upper benote also identified over." On 8/22/16, at 8:53 had complained of and was unable to a full lift to transfer On 8/22/16, at 4:31 complaining of pain transferring in the Edevice).	e of 2 staff with transfers. It plan revised 3/25/16, If functioning ADL (activities of with interventions that included to of one staff and EZ stand lift use 2 staff PRN (as needed). It provides the property interdisciplinary resident 6, identified R9 required ADL gransfers with stand lift. The sistant (NA) care sheet entified R9 requiring the EZ for transfers. It is nurses notes the following p.m. the note identified a situation had occurred. It the note that R9 was being the commode to the bed with a down on the floor next to her ner identified minimal pain to R9 had reddish colored bruises that and reddish colored bruises that and reddish colored that R9 right thigh pain at 6:00 a.m., stand and required staff to use	F3	09				

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE D1 SOUTH HILL STREET A CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	was having marked to utilize the EZ sta transfer safely. The lift was used to transed time. R9 was more (cm) red scrape be outer aspect of her the note at 11:27 puthe right not the left had a large light puth was raised and star around the entire how was identified as be measured 6 cm by area was warm to the in pain with use of the gently in bed. On 8/23/16, at 8:35 transferred with a file 8/23/16, at 9:30 a.m. pain in her right this having a large hem and movement. R9 was transferred on 8/23/16. A note (ER) dated 8/23/16 right leg was shorten note from 8/23/16, ER identified that File the facility and state fracture of the right from the hospital dap.m.) identified R9 if fracture. The note it to skin and R9 dem	d weakness when attempting and and was not able to be note further indicated a full asfer R9 back to bed at noted to have a 6 centimeter low her left rib cage, on the left chest. An addendum to am. clarified the scrape was on at. The note also identified R9 urple hematoma (bruise) that are were able to cup their palm ematoma, The hematoma eing firm to touch and 12 cm. R9's upper trochanter rouch. R9 was noticed to wince the lift as well as when rolled a.m. a note identified R9 was all body lift. A note from an identified R9 was having the wind and tender to touch at the hospital at 10:50 a.m. from the emergency room at 11:07 a.m. identified R9's ened and externally rotated. A at 13:06 (1:06 p.m.) from the lated 8/23/16, at 16:02 (4:02 and a severe right femur noticated can see femur close constrated non-verbal and had a very swollen right	F3	809			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245319	B. WING			08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP 101 SOUTH HILL STREET LA CRESCENT, MN 55947	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPF	BE	(X5) COMPLETION DATE
F 309	assistant (NA)-I state morning. NA-I state stated when she trate that day she used a EZ stand as R9 was During interview on stated R9 utilized at the instructions to utindicated on the NA carry with them. During interview on stated she was wor 8/22/16. NA-D state up out of her recline leaning way to the left side, which stated R9 could not pain. NA-D stated nurse immediately, went in to put R9 to again attempted to not put any weight of pale and weak. NA-body lift to get R9 in again told the nurse nurse then went to signs (vs). During interview on assistant director of when R9 was unab going from an EZ lift situation should hav warranted further in	8/23/16, at 11:01 a.m. nursing ted she did not get R9 up that d night shift got R9 up. NA-H unsferred R9 to the wheel chair full body lift rather than the sore on the right side. 8/23/16, at 2:25 p.m. NA-J n EZ stand lift. NA-J stated se the EZ stand lift was a care sheet that the aides 8/23/16, at 2:32 p.m., NA-D king the evening shift on ed when she went to get R9 er with the EZ lift, R9 was eff putting all of her weight on was not usual for R9. NA-D stand and was wincing with at that time she notified the NA-D stated that when she bed later that evening she use the EZ lift and R9 would on her right leg and was very D stated staff then used a full no bed. NA-D stated she of R9's condition and the check on R9 and took vital 8/24/16, at 11:21 a.m. the form the state of R9 and took vital state to transfer her typical way, it to a full body lift, the ve been looked into and vestigation. The ADON one considered a change of	F 3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		10	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET A CRESCENT, MN 55947		
(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 309	reassessed." The not aware of R9's of to send her to the homotomic to send her to the homotomic transfer belt. During caught on the commuturn to get resident and NA-H slid R9 to grabbed her right less that the day shift on 8/2 approximately 10:0 having trouble keep RN-C stated that NR9 was moaning and complaining of her During interview on stated she had wor RN-A stated she was transferring poorly of the aides didn't feel EZ stand lift. RN-A look at R9 which she was assistated, at around 10 leg was "out of synchematoma on R9's on her side. RN-A while staff were turn	ADON further stated she was ondition until they were going pospital. 8/24/16, at 3:05 p.m. NA-H asferring R9 from the sed on 8/21/16 and utilized a gothe transfer R9 gother heel mode and when NA-H went to onto the bed, R9 fell into her of the floor. NA-H stated R9 and complained of pain. 8/24/16, at 3:32 p.m. N)-C stated she was working 2/16. RN-C stated that at 0 a.m. an aide told her R9 was bing her feet on the EZ lift. A-A had reported to her that and groaning a lot and	F3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245319	B. WING	i		08/26/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER - LA	CRESCENT		1	STREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	than the other but of the night shift her file	see if one leg was shorter locumented and reported off to indings. 8/25/16, at 6:27 a.m. NA-K ked the night of the 8/21/16. not reported to the NA's that on the evening shift. NA-K swollen and sore and R9 ed during the night. NA-K ent to get R9 up in the morning was crying and moaning in transfer NA-K stated the gave R9 a pain medication and ing to look at R9's leg in the ted when she sat R9 up R9 and started moaning and into on her right leg. NA-K really bad and she wouldn't twas swollen at that time." 8/25/16, at 6:40 a.m. NA-L ed of pain when she was so stated R9's leg was swollen wement and stated, "Anytime rimaced and complained of 8/25/16, at 9:37 a.m. NA-A ked the day shift 8/22/16. s very restless and tired and eyes when her name was be unusual for R9. NA-A e EZ stand as that is what the NA-A stated R9 had a lot of the R9 was different than her insferring well and kept	F3	309			

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245319	B. WING _		08	/26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	daughter (FA)-A stawhen her mother we FA-A stated her mother was "excruciating to seen the x-ray of horizon had pointed broken at an angle inches. The daugh not notice this, Her inches shorter? I do try to stand her up! During interview or stated she was on the floor. LPN-B storicity bruising, did a little think the right leg at the morning pain the mother may have had restremity and state fall." RN-D stated end of the shift and difficulty transferring the night of 8/22/16 R9 was having pain repositioning. NA-E the morning before the morning before the morning before and inability to transform documentation idea.	n 8/25/16, at 11:30 a.m. R9's ated she was at the hospital vas transferred on 8/23/16. Other was in so much pain it o watch." FA-A stated she had er mother's right leg and the ed out that the femur was and it was over-lapping 3 of the also stated, "How did they foot was sideways and 3 on't know how they could even." n 8/25/16, at 11:53 a.m. LPN-B duty when R9 was lowered to tated she did not notice range of motion and didn't appeared to be fractured. n 8/26/16, RN-D stated R9 was brining of 8/22/16. RN-D stated more pain in the right lower ed, "She will have pain after a NA-K had caught her at the direported R9 had pain and g. RN-D further stated that on 6 to 8/23/16, the NA's reported in her right leg with 0 stated she gave R9 Tylenol in eshe got up. th the ADON on 8/24/16, at 11:1 verified the physician should sooner of R9's increased pain sfer. The ADON verified the intified R9 had been in, had swelling of her leg, and	F 30	09		

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY MPLETED
		245319	B. WING _		08/	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	The facility policy "I Resident Health St identified the facility physician, nurse pr assistant when their results in injury and physician interventing R38 was admitted diagnoses including failure, atrial fibrillar insufficiency, and nadmission record face R38's 14-day admit a brief interview for 12 indicating mode The MDS further in dependence with the extensive assistant locomotion on/off upersonal hygiene. Of altered skin integ 8/1/16. Intervention skin inspection. Mo of infection such as discharge, odor, not findings. Skin assectiving Center Policies. Review of the Wee and 8/23/16 indicate reviews did not included the following Review of the nursinurse (RN)-A dated included the following reviews of the nursinurse (RN)-A dated included the following reviews of the nursinurse (RN)-A dated included the following reviews of the nursinurse (RN)-A dated included the following reviews of the nursinurse (RN)-A dated included the following reviews of the nursinurse (RN)-A dated included the following reviews did not inclu	Notification of Change in atus" last reviewed 11/11/15, y would consult the residents actitioner or physician re was: (A) An accident which had the potential for requiring ion." to the facility on 7/19/16 with g unspecified fall, acute kidney tion, chronic peripheral venous nacular degeneration per the ace sheet. ssion data set (MDS) included mental status (BIMS) score of trate cognitive impairment. Indicated R38 required total ransfers and bathing, and the with bed mobility, anit, dressing, toilet use, and The care plan included a focus grity non pressure initiated ins included: Conduct weekly onitor for signs and symptoms as swelling, redness, warm, of tify physician of significant ressment to be completed per y. Skly Skin Reviews dated 8/9/16 ted: Skin Intact. The skin lude evidence of other skin	F 30	09		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(E SURVEY PLETED
		245319	B. WING			08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP COI 101 SOUTH HILL STREET LA CRESCENT, MN 55947	ΣE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD E	3E	(X5) COMPLETION DATE
F 309	full lift for transfers both bladder and st measurements of the evidence of notifical nursing staff. A substance by RN-A dated included: "Did requisioned included: "Did requisioned included: "Did requisioned include evidence of progress note dated. The progress note dated. The progress note dated. The progress note include evidence of progress note of L (left) upshoulder to L elbow on lateral L thoracid body that appear to on admission assess. There is a brief noted dated 8/10/16 @ (a bruise from shoulde Background: Last from the living center) since admission here has rehab. (rehabilitation does not include plapathology. Noted to confusion on 8/16/1 old). Assessment:	ge 47 In to touch. Continues to need and remains incontinent of cool." The note did not include the left arm bruising nor tion to the physician or other osequent nursing progress in 8/14/16 at 23:13 (11:13 p.m.) the process of the	F3	09			

-	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED				
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		10	REET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HILL STREET A CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	cm W (wide) is dk. thoracic 8 cm L x 1 soft. No palpable f This writer is unable chart re: a CBC (count result. Resp Temporary Problem (licensed) nursing and charting. This issue to Dr. [physic writer is not certain occurrence due to General Note/Progerare). Further review of the dated 8/17/16 and R38's left upper arrow The medical record the bruising after 8. Review of electronic record (eTAR) date monitoring of R38's When interviewed stated when a new identified the charger resident and initiate background, assess The nurse would that temporary care per change in conditions Surveyor reviewed written by RN-A per bruising. RN-A corbruising to the left of the shoulder to the	purple and soft. Lateral L 0 cm W is a lighter purple, irm areas on either location. e to find a lab report in paper amplete blood count) or platelet onse: This writer initiated a n for communication to lic staff for on-going assessment writer will fax a note re: this ian name] at local clinic. This that bruising is new the notation in the 8/10/16 ress Notes in PCC (point click one nursing progress notes 8/18/16 included charting on and left thoracic bruising. It did not include monitoring of 1/18/16.		809			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/	26/2016		
	PROVIDER OR SUPPLIER	CRESCENT		101	REET ADDRESS, CITY, STATE, ZIP CODE I SOUTH HILL STREET CRESCENT, MN 55947	,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 309	resident. RN-A star completed an SBAI physician and confirence of RN-A further verified passed on to the new possible causes who when interviewed director of nursing dissue is identified the source of the skin is complete an SBAR to the temporary propert of the charge nurse identify a new skin measured though romeasure again, but the bruising was gowere measured we unless there was a stated she was unabruising first identifies subsequently on 8/prone to bruising as to admission to the many bruises upon R38's medical recowas not admitted we confirmed the large origin to R38's left assessed with com reported to the physical process of the physical	sing was unusual for the ted she should have R note and notified the rmed that had not been done. It is determined that had not been dext shift nor investigated for men identified on 8/10/16. On 8/26/16, at 8:46 a.m. the (DON) stated when a new skin men ruse should investigate the saue, notify the physician, note, and add the skin issue oblem list to pass on to the assistants (NA's) are also to be known as soon as they concern. Bruises are initially mursing wouldn't necessarily it would monitor and indicate if etting better or worse; wounds ekly - bruises not necessarily significant change. DON tware of R38's left arm	F3	809					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		TE SURVEY MPLETED
		245319	B. WING		08	/26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	visitors. DON atter arm from his long is became resistive a Surveyor and DON portion of the left a left shoulder to the purple bruising not posterior portion of continued to extend confirmed the bruising at a lat. When interviewed the communication both bruising at a lat. When interviewed the communication both bruising dated 8/17 the shift responsible "all". DON stated with the expectation was monitoring and mand to the status of the confirmed R38's bruising per the progres to the eTAR for cordinating; left poster measured 28 centile wide. The bruising measurement on 8 A policy on skin was R28's Significant C (MDS) assessment.	red in w/c in room with 2 male mpted to remove R38's left sleeve shirt but resident and thus attempt was stopped. I were able to visualize a rm bruising from below R38's mid upper arm; dark reddished that surrounded the the resident's upper arm and downards the elbow. DON sing continued to be significant apt to visualize and measure ter time. on 8/26/16, at 9:37 a.m. the nursing temporary problem ok which identified R38's ref. The form indicated that e for documentation indicated with this communication tool is that nursing would be king a chart note daily related bruising until healed. DON ruising had not been monitored tess notes nor had been added antinued monitoring. roximately 1:00 p.m. the DON ments of R38's left arm fror upper arm bruising meters (cm) long x 16 cm and had increased from the last	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	TE SURVEY MPLETED
		245319	B. WING		08	3/26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP COI 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	R28's care plan da received hospice of coordinate the care family informed of a notify hospice of ar medication change. The hospice care programmed for a notify hospice care programmed for a needed nurse visits weeks and as needed nurse visits weeks and interview licensed practical results and when the contact the pulletin board in further verified they	erate cognitive impairment. ted 6/2/16, identified that R28 entered care and staff were to e plan with Hospice, keep the change in condition and to ny change in condition or es. plan dated 5/18/16 indicated a gement with weekly and as a and social work visits every 6 ded. tion on 8/24/16, at 9:07 a.m. in her recliner chair eating her s alert, neatly dressed and	F3	09		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/	26/2016	
	PROVIDER OR SUPPLIER	CRESCENT		1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	p.m. the triage hosp would bring out con "They had to have reverified that hospice the day of the visit a changes within the The triage nurse into on Thursdays. During interview on administrator indicate hospice to let them often the hospice wisit. She stated, "With hospice unless all their staff". During interview or director of nursing (expect a visit scheen hospice organization there were no contains.	_	F3	809				
F 312 SS=D	but was not provide 483.25(a)(3) ADL C DEPENDENT RES A resident who is undaily living receives	is requested from the facility id.	F 3	s12			9/23/16	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245319	B. WING		08/	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947	, 55	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	Continued From pa	nge 53	F 312	2		
	by: Based on observar review, the facility for 3 residents (R12 living (ADL's). Findings include: R12 had been obset at 4:58 p.m. R12 w long, jagged fingers substance underned confirmed her nails stated she needed were too long. On 8/24/16, at 10:2 lying in bed. During noted to continue to that were soiled unnoted have a black thumb cuticle. R12 observation and stanails cut and that sometime later in the On 8/24/16, at 4:00 long, jagged and disubstance remaining stated, staff had no nails and she wasn. On 8/25/16, at 7:31 her room with nails dirty with the black/	tion, interview and document ailed to provide nail care for 1) reviewed for activities of daily erved during cares on 8/22/16, as observed in her room with nails with dark brown eath on both hands. R12 were long and soiled and to have her nails cut as they estated as they large and solved and to have long, jagged fingernails derneath. R12 was further brown substance on her left exact she needed to have her taff were going to do it ne day. 10 p.m. R12's nails remained rty with the black/brown ag on the left thumb. R12 to come to her room to cut her 't sure when they would. 12 a.m. R12 was observed in remaining long, jagged and derown substance still present uticle. R12 also stated her		1. Resident R12 had nail care pr 2. All residents that are unable to activities of daily living had potent affected. 3. Nursing staff have been educated providing nail care with bathing an needed. 4. DNS or designee will completed audits on pain management, were inspections and hospice community weekly for four weeks then month two months. Results will be communicated to facility QAPI communicated to facility QAPI communicated.	carry out tial to be ted on nd as random kly skin nication nly for	

-	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		1	OTREET ADDRESS, CITY, STATE, ZIP CODE O1 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	nails were too long R12's quarterly min assessment dated a Interview for Menta score of 11 indicatir impairment. The M required extensive a hygiene. Review of R12's cu identified R12 recei Friday mornings and that was to be remoof R9's bath schedulad received a bath identified staff were DO NAIL CARE!! Tidentified R12 requi with personal hygied (PRN). R12 also hapalm guard in the Ahand hygiene which review report dated When interviewed on ursing assistant (No bath on Fridays and her nails. She state not get done becaut instead of a tub bat like R12's nail care bed bath on Friday. were long, jagged a would clean and trin NA-B also stated, "Interview of the page of the	and she needed them cut. imum data set (MDS) 8/10/16, included a Brief I Status (BIMS) assessment ag moderate cognitive IDS also identified that R12 assistance with personal rrent resident care sheet ved a weekly bed bath on d had a splint to the left hand oved daily for hygiene. Review alle for 8/19/16, indicated R12 a. The bath schedule to PLEASE REMEMBER TO the care plan revised 8/24/16, red assistance of one staff and an order to remove her a was indicated on the order	F3	312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE S	
		245319	B. WING		08/20	6/2016
	PROVIDER OR SUPPLIER	CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(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) COMPLETION DATE
F 312 F 323 SS=G	director of nursing (have had nail care) The DON further coresponsible for nail their bath regardles bath is given. Review of the facilit reviewed 12/7/15, in PROCEDURE: 14. toenails is part of the clean. 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remain as is possible; and	on 8/25/16, at 11:00 a.m. the (DON) confirmed R12 should provided per her plan of care. On firmed the NA's were care when resident's received as if a bed bath, shower or tub crypolicy for Bed bath, last included: Care of fingernails and the bath. Be certain nails are	F 3		ę	9/23/16
	by: Based on observate review, the facility for manner that promotorisk (R9 & R14) in the services in a safe means who sustained a right Findings include:	NT is not met as evidenced cion, interview and document ailed to provide services in a ted safety for 2 of 3 residents ample who were identified at illure of the facility to provide nanner resulted in harm to R9 ht femur fracture.		 Resident R9 uses stand lift fo transfers. resident R14 has alarn place on bed and wheelchair. All residents who use mechan or alarms had potential to be affed. Nursing staff have been educated providing services in a manner to accidents. DNS or designee will completed audits on lift use and alarm use. for four weeks then monthly for the 	ns in ical lifts ected. ated o prevent e random Weekly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIER	CRESCENT		1	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET .A CRESCENT, MN 55947	00/1	20/2010
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	including dementia current pathologica R9 was observed on her room in her was moaning. An interversellessness and marespond appropriate R9's significant chases assessment dated Brief Interview for MOO indicating R9 has impairment. The Coassociated with the for falls and fall related extensive assistants. Review of R9's care identified a physical interventions that in one staff and EZ staneeded). Review of resident review data required ADL assist stand lift. The certicare sheet updated requiring the EZ staneeded: On 8/21/16, at 9:54 change of condition was documented in transferred from the transfer belt and slibed. The note furth	and osteoporosis without I fracture. on 8/22/16, at 5:24 p.m. sitting wheelchair restless and riew was attempted about her toaning but R9 was unable to ely to questions. onge Minimum Data Set (MDS) 5/18/16, identified R9 with a Mental Status (BIMS) score of d severe cognitive are Area Assessment (CAA) MDS identified R9 was at risk atted injuries and required are of 2 staff with transfers. on plan revised 3/25/16, I functioning ADL/deficit with a reluded transfers with assist of and lift or use 2 staff PRN (as a the quarterly interdisciplinary and 8/15/16, identified R9 and and 1 assist for transfers. on nurses notes the following	F3	323	months. Results will be reported to QAPI committee.	facility	

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	CRESCENT		1	STREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	on her right upper to note also identified over." On 8/22/16, at 8:53 had complained of and was unable to a full lift to transfer On 8/22/16, at 4:31 complaining of pain transferring in the Edevice). On 8/22/16, at 10:2 was having marked to utilize the EZ statransfer safely. The lift was used to get R9 was noted to has crape below her leleft chest. An adder p.m. clarified the soleft. The note also in purple hematoma (I staff were able to conhematoma, The hebeing firm to touch R9's upper trocham R9 was noticed to was well as when roll On 8/23/16, at 9:30 a.m pain in her right thig	a.m. a note identified that R9 right thigh pain at 6:00 a.m., stand and required staff to use R9. p.m. a note identified R9 was to her right thigh while Z stand (mechanical lift 28 p.m. a note identified R9 was to her right thigh while Z stand (mechanical lift 28 p.m. a note identified R9 weakness when attempting and and was not able to e note further indicated a full R9 back to bed at bedtime. We a 6 centimeter (cm) red off rib cage, on outer aspect of and to the note on 11:27 rape was on the right not the dentified R9 had a large light boruise) that was raised and up their palm around the entire ematoma was identified as and measured 6 cm by 12 cm. ter area was warm to touch. Wince in pain with use of the lift	F3	323			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	R9 was transferred A note from the em. 8/23/16, at 11:07 a. shortened and exte 8/23/16, at 13:06 (1 identified that R9's facility and stated R fracture of the right from the hospital dap.m.) identified R9 I fracture. The note in to skin and R9 dem indicators of pain and femur/hip area. During interview on stated R9 utilized at the instructions to unidicated on the NA carry with them. During interview on stated she was wor 8/22/16. NA-D stated pout of her recline leaning way to the left side, which stated R9 could not pain. NA-D stated nurse immediately, went in to put R9 to again attempted to not put any weight of pale and weak. NA-body lift to get R9 in again told the nurse	to the hospital at 10:50 a.m., ergency room (ER) dated m. identified R9's right leg was rnally rotated. A note from :06 p.m.) from the ER physician had contacted the in the interest of phase severe right femur. An admission note ated 8/23/16, at 16:02 (4:02 had a severe right femur andicated can see femur close constrated non-verbal and had a very swollen right in the EZ stand lift. NA-J stated is the EZ stand lift was a care sheet that the aides in the interest of the in	F3	323			

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245319	B. WING			08/	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT		1	OTREET ADDRESS, CITY, STATE, ZIP CODE O1 SOUTH HILL STREET LA CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	During interview on assistant director owhen R9 was unabgoing from an EZ lisituation should hawarranted further instated,"This would condition for [R9] a reassessed." The not aware of R9's ot osend her to the houring interview on stated she was transfer belt. During caught on the computurn to get resident and NA-H slid R9 to grabbed her right led. During interview on stated she had wor RN-A stated she was transferring poorly the aides didn't fee EZ stand lift. RN-A look at R9 which she signs. which were for was grimacing and when she was assistated, at around 1 leg was "out of synchematoma on R9's on her side. RN-A while staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were tur weaker and having she did not check to state the staff were turn weaker and having she did not check to state the staff were turn weaker and having she did not check to state the staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker and having she did not check to staff were turn weaker	1 8/24/16, at 11:21 a.m. the f nursing (ADON) stated that le to transfer her typical way, ft to a full body lift, the ve been looked into and nvestigation. The ADON be considered a change of nd she should have been ADON further stated she was condition until they were going		323			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT			STREET ADDRESS, CITY, STATE, ZIP CO 101 SOUTH HILL STREET LA CRESCENT, MN 55947				
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	the night shift her find the night shift her f	indings. 1 8/25/16, at 6:27 a.m. NA-K red the night of the 8/21/16. not reported to the NA's that on the evening shift. NA-K red during the night. NA-K red during the night. NA-K rent to get R9 up in the morning was crying and moaning in transfer NA-K stated the gave R9 a pain medication and red to look at R9's leg in the red when she sat R9 up R9 and started moaning and red the started wouldn't really bad and she wouldn't red the day shift 8/22/16. It was swollen at that time." 1 8/25/16, at 9:37 a.m. NA-A red the day shift 8/22/16. It was swollen at that time was be unusual for R9. NA-A red EZ stand as that is what the set. NA-A stated R9 had a lot of rers which was reported to the R9 was different than her red referring well and kept	F 32	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT			STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947					
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F 323	inches. The daugh not notice this, Her inches shorter? I do try to stand her up! During interview on stated she was on the floor. LPN-B st bruising, did a little think the right leg at During interview on having pain the mo R9 may have had rextremity and state fall." RN-D stated I end of the shift and difficulty transferring the night of 8/22/16 R9 was having pain repositioning. NA-D the morning before The facility policy "Nesident Health Staidentified the facility physician, nurse proassistant when their results in injury and physician intervention R14 was admitted the dementia, chronic of (CODP), depression per the admission results in results in results in results in results in results in injury and physician intervention results in injury and physician results in injury and results in inju	ter also stated, "How did they foot was sideways and 3 on't know how they could even " 8/25/16, at 11:53 a.m. LPN-B duty when R9 was lowered to ated she did not notice range of motion and didn't ppeared to be fractured. 8/26/16, RN-D stated R9 was rning of 8/22/16. RN-D stated nore pain in the right lower d,"She will have pain after a NA-K had caught her at the reported R9 had pain and g. RN-D further stated that on to 8/23/16, the NA's reported in her right leg with stated she gave R9 Tylenol in she got up. Notification of Change in atus" last reviewed 11/11/15, would consult the residents actitioner or physician re was: (A) An accident which I had the potential for requiring on."		323				
	assessment dated	7/16/16, indicated R14 assistance with toilet use,						

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT				101	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH HILL STREET CRESCENT, MN 55947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	dressing, and person with one person pherobility, transfer, and R14's care plan lass risk for falls. Interview W/C (wheelchair) and adily for proper fundamentary assistant as utilized a bed and of the working assistant (Not assistance with transport of the wall with her leg of the bed. R14's working on the resident's head the wall with her leg of the bed. R14's working on the resident's head the wall with her leg of the bed. R14's working on the resident's head the wall with her leg of the bed. R14's working on the resident's head observed to the bed by the working on the resistent alarm was not in pla and should have be working on the resistent alarm the day be worked to the bed by the day of the bed	onal hygiene, and supervision ysical assistance with bed and locomotion off the unit. It revised 4/4/16, indicated a entions included: "Bed and larms in place and checked ctioning." Review of the ssignment sheet identified R14 hair alarm for safety. In 8/24/16, at 3:20 p.m. IA)-D stated R14 required ansfers and toileting though sk staff for assistance. NA-D 14 is in bed, she would often by was unsure if the resident		323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/:	26/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT				STREET ADDRESS, CITY, STATE, ZIP C 101 SOUTH HILL STREET LA CRESCENT, MN 55947	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 323	positioned R14's w/brakes locked then assistant director of was in need of a bethe ADON and NAsensor pad alarm. R14 in bed while the pad underneath the able to place the seresident though R1 repositioning. NAserefused morning cawho had assisted the day; NA-B was unsalarm earlier. NA-E was unable to locat confirmed the resid when in her w/c and 483.60(b), (d), (e) E LABEL/STORE DR The facility must en a licensed pharmacof records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological labeled in accordant professional princip appropriate access	ave her alone. NA-A /c next to the bed with the exited the room to alert the f nursing (ADON) that R14 ed alarm. Shortly afterwards B entered R14's room with a NA-B attempted to reposition e ADON placed the sensor e resident. The ADON was ensor alarm underneath the 4 continued to refuse B stated the resident had ares earlier though was unsure the resident in getting up for the ure if R14 had utilized an B searched R14's room and the en alarm. The ADON lent was to utilize an alarm d in bed per the plan of care. DRUG RECORDS, EUGS & BIOLOGICALS Imploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an ation; and determines that drug or and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the	F 3	431			9/23/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245319	B. WING _		08/	26/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT			STREET ADDRESS, CITY, STATE, ZIP C 101 SOUTH HILL STREET LA CRESCENT, MN 55947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugontrol Act of 1976 abuse, except whe package drug distriquantity stored is more readily detected. This REQUIREMENT.	State and Federal laws, the all drugs and biologicals in ints under proper temperature tonly authorized personnel to keys. Ovide separately locked, decompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the hinimal and a missing dose can .	F 4:			
	review, the facility f were appropriately medication passes Findings include: R60 had physician insulin aspart, five meals and insulin a orders indicated the between 150 millige 200 mg/dL, two add be administered. During observation 100 wing medication of room 106. Observation	tion, interview and document ailed to ensure medications secured at all times during for 1 of 2 residents (R60). orders dated 8/12/16, for units to be injected before aspart on a sliding scale. The at when R60's blood sugar was rams per deciliter (mg/dL) and ditional units of aspart were to so on 8/24/16, at 5:05 p.m., the on cart was positioned outside ervations at that time revealed (N)-A removed R60's Novolog		 Facility ensures medication appropriately secured during repass. All residents had the potent affected by medication left on 3. Any staff who would adminimedications have been educated properly securing medication pass. DNS or designee will compand audits on properly securing medication pass weeks then monthly for two many medicated to fact committee. 	medication ial to be cart. ster ted on during lete random edication y for four onths.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245319	B. WING			08/	26/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT				101 SC	T ADDRESS, CITY, STATE, ZIP CODE DUTH HILL STREET RESCENT, MN 55947	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	cart drawer, wasted pen to five units and of the medication cart whis sugar. Observation walked away from the 112 located near the RN-A then checked 112. When the blocompleted, RN-A restill positioned outs Observations at the and two visitors we the medication cart pen, dialed two most and returned to addrawed in the stand that the stand two wasted that the medication cart pen, dialed two most and returned to addrawed in the stand that t	sulin pen from the medication of two units of insulin, dialed the diplaced the insulin pen on top art. RN-A stated the routine sulin and leave it on top of the le RN-A checked R60's blood at that time revealed RN-A the medication cart to room the end of the 100 wing hallway. I R60's blood sugar in room to do sugar check was eturned to the medication cart, and time revealed two residents are standing at room 109 near. RN-A removed the insuling reflect the insuling the units to equal seven units, minister the insuling to the werified she expected to cked in the medication cart ded on top of the medication of edication cart is kept closed at of sight of the medication medications are kept on top of the ering medications, and all the be inaccessible to residents.	F 4	.31				

F534025

PRINTED: 09/28/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245319 B. WING 08/23/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 SOUTH HILL STREET **GOLDEN LIVINGCENTER - LA CRESCENT** LA CRESCENT, MN 55947 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 8/23/2016, Golden Livingcenter - La Crescent was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

09/20/2016

Electronically Signed

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER® A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED 08/23/2016	
		245319					
	PROVIDER OR SUPPLIEF			101	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH HILL STREET CRESCENT, MN 55947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defication of the correct the description of the correct the correct and the correct thas correct the correct the correct the correct the correct the co	state.mn.us and an@state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rection and monitoring to rence of the deficiency. gcenter - La Crescent, is a ith no basement. The facility in 1968 and was determined to	K	000			
K 067	alarm system with and spaces open for automatic fire. The facility has a census of 37 beds The requirement a NOT MET as evid			067			9/23/16
SS=F	Heating, ventilating with the provision in accordance with	AFETY CODE STANDARD ig, and air conditioning comply s of section 9.2 and are installed the manufacturer's 19.5.2.1, 9.2, NFPA 90A,		067			9123110

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	IPLE CONSTRU IG 01 - Main e	COMPLETED			
		245319	B. WING		14	08/	/23/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT		STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947					
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF COF ICH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 067				1. Waiv	ver request for this dubmitted.	leficiency has	
		ctice was confirmed by the ce Director (MO) at the time of					

Name of Facility **2000 CODE** Golden LivingCenter-La Crescent PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s). PROVISION NUMBER(S) **JUSTIFICATION** K84 A waiver is requested for K067 for the following reasons: K067 A) There will be no adverse effects on the health and safety of the facility's residents and staff since: 1. The building is equipped with an approved corridor smoke detection system 2. The building has automatic shut down of ventilation fans/HVAC system upon detection of smoke or activation of the building fire alarm system. 3. Annual service and maintenance contracts exist to service all the facility's fire protection systems (for example: fire alarms, sprinkler system, portable extinguishers). 4. The building fire alarm system is monitored to provide automatic fire department notification. 5. Fire safety training is provided for employees on an annual basis and during orientation for new hires. 6. Fire drills are conducted at least quarterly on each shift. 7. The facility is protected by a supervised automatic sprinkler system. B) Compliance with this provision would impose an unreasonable hardship on the facility since: 1. It would cost an estimated \$242,168.00 to upgrade the HVAC system to comply with the NPPA 90A. This firgure does not include upgrading the electrical system to accommodate the HVAC equipment. C) This tag was previously sited and recommendations were reviewed. A waiver for this tag is requested.

Surveyor (Signature)	Title	Office	Date
-1 0 /	2		
Fire Authority Official (Signature)	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal Division	10/05/2016



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 12, 2016

Ms. Abby Rand, Administrator Golden Livingcenter - La Crescent 101 South Hill Street La Crescent, MN 55947

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5319025

Dear Ms. Rand:

The above facility was surveyed on August 22, 2016 through August 26, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Golden LivingCenter - La Crescent September 12, 2016 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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 Initial Comments		2 000				
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber and many of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	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 Depa Informational Bullet http://www.health.si	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

09/22/16 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 72 C98F11

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S I'H HILL STRI CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's provider and the fol issued. Please indicorrection that you and identify the date. Minnesota Department's provider and the fol issued. Please indicorrection that you and identify the date. Minnesota Department's provider and the fol issued. Please indicorrection that you and identify the date. Minnesota Department the State Licensing federal software. Ta assigned to Minnesota Department the State Licensing federal software. Ta assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of c "Summary Statement and replaces the "T correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corpus PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA"	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 24, 25, & 26, 2016, surveyors is staff, visited the above lowing correction orders are cate in your electronic plan of have reviewed these orders, is when they will be completed. The ent of Health is documenting and numbers have been soft a state statutes/rules for the prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the state statute in violation of the state statute in the surveyors findings method of Correction and crection. IRD THE HEADING OF THE	2 000			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00936	B. WING		08/2	6/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 000	Continued From page 2		2 000				
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
2 265	5 MN Rule 4658.0085 Notification of Chg in Resident Health Status		2 265			9/23/16	
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the	ust develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an a must be involved in the use policies. The policies must address at least the tion times for:					
		involving the resident which I has the potential for requiring on;					
	physical, mental, o example, a deterior	change in the resident's or psychosocial status, for ration in health, mental, or in either life-threatening al complications;					
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;					
	D. a decision tresident from the n	to transfer or discharge the ursing home; or					

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 3 of 72 C98F11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	ORESS, CITY, S TH HILL STR CENT, MN 5			
(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
2 265	•		2 265			
	E. expected an	d unexpected resident deaths.				
	This MN Requireme	ent is not met as evidenced				
	Based on observation, interview and document review, the facility failed to notify the physician of pain/injury following a fall for 1 of 3 (R9) who had a fall that resulted in harm evidenced by pain related to a fracture of the femur for R9. Further, the facility failed to notify the physician of significant bruising for 1 of 1 resident (R38) with significant bruising of unknown origin when initially identified.			Corrected		
	Findings include:					
		nission record identified g dementia and osteoporosis nological fracture.				
	R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair. She was restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions.					
	assessment dated some street of the street o	nge Minimum Data Set (MDS) 5/18/16, identified R9 with a Mental Status (BIMS) score of d severe cognitive are Area Assessment (CAA) MDS identified R9 was at risk atted injuries and required the of 2 staff with transfers.				
	During review of the entries were noted:	e nurses notes the following				
	On 8/21/16, at 9:54	p.m. the note identified a				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	change of condition was documented in transferred from the transfer belt and slibed. The note furth the right side and the bruises on her right arm. The note also pain "all over." On 8/22/16, at 8:53 had complained of and was unable to a full lift to transfer. On 8/22/16, at 4:31 complaining of pain transferring in the Edevice). On 8/22/16, at 10:2 was having marked to utilize the EZ stat transfer safely. The lift was used to transbedtime. R9 was n (cm) red scrape belouter aspect of her the note on 11:27 pthe right not the left had a large light pure was raised and staf around the entire he was identified as be measured 6 cm by area was warm to the in pain with use of the gently in bed.	a situation had occurred. It the note that R9 was being a commode to the bed with a d down on the floor next to her her identified minimal pain to hat R9 had reddish colored upper back under her right identified R9 stated she had a.m. a note identified that R9 right thigh pain at 6:00 a.m., stand and required staff to use	2 265			

Minnesota Department of Health

STATE FORM 6899 C98F11 If continuation sheet 5 of 72

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5				
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 265	5 Continued From page 5		2 265				
	8/23/16, at 9:30 a.n pain in her right thic having a large hem and movement. R9 was transferred						
	R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.						
	assistant (NA)-I state morning. NA-I state stated when she tra that day she used a	1 8/23/16, at 11:01 a.m. nursing ated she did not get R9 up that and night shift got R9 up. NA-H cansferred R9 to the wheel chair a full body lift rather than the s sore on the right side.					
	stated R9 utilized a the instructions to u	n 8/23/16, at 2:25 p.m. NA-J n EZ stand lift. NA-J stated use the EZ stand lift were A care sheet that the aides					
	stated she was wor 8/22/16. NA-D stat up out of her reclind leaning way to the l	kin 8/23/16, at 2:32 p.m., NA-D rking the evening shift on ted when she went to get R9 er with the EZ lift, R9 was left putting all of her weight on was not usual for R9. NA-D					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(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)	ON SHOULD BE COMPLETE BE APPROPRIATE DATE	
2 265	stated R9 could not pain. NA-D stated nurse immediately. went in to put R9 to again attempted to not put any weight pale and weak. NA body lift to get R9 in again told the nurse nurse then went to signs (VS). During interview on assistant director owhen R9 was unab going from an EZ li situation should haverranted further in stated, "This would condition for R9." During interview on stated she was trancommode to the betransfer belt. During caught on the commuturn to get the resid her and NA-H slid R9 grabbed her rigil. During interview on registered nurse (R the day shift on 8/2 approximately 10:0 having trouble keep RN-C stated that N R9 was moaning ar complaining of her on 8/24/16, at 2:55	ge 6 Is stand and was wincing with at that time she notified the NA-D stated that when she bed later that evening she use the EZ lift and R9 would on her right leg and was very D stated staff then used a full no bed. NA-D stated she of R9's condition and the check on R9 and took vital 8/24/16, at 11:21 a.m. the finursing (ADON) stated that le to transfer her typical way, fit to a full body lift, the we been looked into and evestigation. The ADON be considered a change of 8/24/16, at 3:05 p.m. NA-H asferring R9 from the ed on 8/21/16 and utilized a goal the transfer R9 got her heel mode and when NA-H went to lent onto the bed, R9 fell into R9 to the floor. NA-H stated and leg and complained of pain. 8/24/16, at 3:32 p.m. 8/24/16, at 3:32 p.m. 8/24/16, at 3:32 p.m. 18/24/16, at 3:32 p.m.	2 265			

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	A CRESCENT 101 SOUT	DRESS, CITY, S' I'H HILL STRE CENT, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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
2 265	was told in report the during the day. RN safe transferring RS stated staff asked he did and she took RS further stated R9 who be in a lot of pain who bed. RN-A also stanotice R9's right leg noted the "huge" he "huge" scrape on he facial grimaces whistating, "She was who pain.". RN-A stated one leg was shorted documented and refindings.	nat R9 was transferring poorly I-A stated the aides didn't feel 9 with the EZ stand lift. RN-A ner to go look at R9 which she 9's v.s. which were fine. RN-A was grimacing and appeared to when she was assisted into when she was assisted into ated, at around 10:00 p.m. she gwas "out of sync" and she ematoma on R9's thigh and the er side. RN-A stated R9 had le staff were turning her eaker and having a lot of she did not check to see if a than the other but exported off to the night shift her	2 265			
	stated she had wor NA-K stated it was R9 had an incident stated R9's leg was asked for a pain me stated when she we with the EZ lift, R9 pain and could not nurse went in and estated she was goin morning. NA-K stated she was goin morning. NA-K stated she was goin could not bear weig stated, "Her leg hur put pressure on it, in During interview on stated she worked complained of pain NA-L also stated R	ked the night of the 8/21/16. not reported to the NA's that on the evening shift. NA-K is swollen and sore and R9 and during the night. NA-K ent to get R9 up in the morning was crying and moaning in transfer NA-K stated the gave R9 a pain medication and ing to look at R9's leg in the ted when she sat R9 up R9 and started moaning and ght on her right leg. NA-K it really bad and she wouldn't it was swollen at that time." 1.8/25/16, at 6:40 a.m. NA-L Monday (8/22/16) and R9 when she was rolled over. 9's leg was swollen and painful it stated, "Anytime we rolled"				

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AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DRESS, CITY, S FH HILL STR CENT, MN 5			
(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
2 265	her she grimaced as During interview on stated she had wor NA-A stated R9 wa would not open her called which would stated she used the care plan indicated pain with the transfenurse. NA-A stated normal, was not trarepeating she had puring interview on stated she was on the floor. LPN-B st bruising, did a little think the right leg as During interview on stated R9 was havi 8/22/16. RN-D state pain in the right low will have pain after caught her at the enhad pain and difficustated that on the nNA's reported R9 with repositioning. If Tylenol in the morn During interview with 21 a.m. the ADON have been notified and inability to transdocumentation ider	and complained of pain." 8/25/16, at 9:37 a.m. NA-A ked the day shift 8/22/16. It is very restless and tired and eyes when her name was be unusual for R9. NA-A at EZ stand as that is what the NA-A stated R9 had a lot of ers which was reported to the R9 was different than her insferring well and kept pain. 8/25/16, at 11:53 a.m. LPN-B duty when R9 was lowered to ated she did not notice range of motion and didn't inpeared to be fractured. 8/26/16, at 8:35 a.m. RN-D ing pain the morning of ead R9 may have had more reter extremity and stated, "She at fall." RN-D stated NA-K had and of the shift and reported R9 at fall." RN-D stated NA-K had and of the shift and reported R9 at fall. "RN-D stated NA-K had and of the shift and reported R9 at fall." RN-D stated NA-K had and of the shift and reported R9 at fall. "RN-D stated NA-K had and of the shift and reported R9 at fall." RN-D stated NA-K had not of the shift and reported R9 and of the physician should sooner of R9's increased pain after. The ADON on 8/24/16, at 11: verified the physician should sooner of R9's increased pain after. The ADON verified the intified R9 had been had swelling of her leg, and	2 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DRESS, CITY, S TH HILL STRI CENT, MN 5			
(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) COMPLETE DATE
2 265	R38 was admitted to diagnoses including failure, atrial fibrillat insufficiency, and madmission record father R38's 14-day admission a brief interview for 12 indicating model. The MDS further in assistance with trarextensive assistance locomotion on/off upersonal hygiene. Of altered skin integ 8/1/16. Intervention skin inspection. Modern of infection such as discharge, odor, not findings. Skin asset Living Center Policy. Review of the Weel and 8/23/16 indicator reviews did not included the following arm from shoulder resident denies painfull lift for transfers both bladder and standard the following staff. A submote by RN-A dated included: "Did requesional requesion included: "Did requesions included: "D	o the facility on 7/19/16 with gunspecified fall, acute kidney ion, chronic peripheral venous acular degeneration per the ace sheet. ssion data set (MDS) included mental status (BIMS) score of rate cognitive impairment. dicated R38 required total asfers and bathing, and se with bed mobility, nit, dressing, toilet use, and The care plan included a focus prity, non pressure, initiated as included: Conduct weekly onitor for signs and symptoms swelling, redness, warm, tify physician of significant assment to be completed per v. kly Skin Reviews dated 8/9/16 ed: Skin Intact. The skin ude evidence of other skin				

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winnesc	<u>ita Department of He</u>	eaith				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00936	B. WING		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	CTDEET AD	DDESS CITY (STATE, ZIP CODE		
INAIVIE OF	FROVIDER OR SUFFLIER		TH HILL STR			
GOLDEN	I LIVINGCENTER - LA	ACRESCENT	CENT, MN 5			
	0.0000000000000000000000000000000000000					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	-	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 265	Continued From pa	iae 10	2 265			
	-	9-1-1				
	effective."					
	Further review of F	R38's medical record revealed				
		of the bruising until a nursing				
		d 8/17/16 at 02:42 (2:42 a.m.).				
	The progress note	indicated: Type: SBAR -				
		on Situation: 0100 (1:00 a.m.)				
		sing assistants) discovered lg.				
		urple bruised area on posterior				
		pper arm extending from L				
		and a smaller bruised area carea of res.'s (resident's)				
		be new and were not present				
		ssment paper form 7/19/16.				
		ation in a Gen. (general) Note				
		it) 2325 re: a L upper arm				
	bruise from shoulde	er to elbow, no measurement.				
		all here at this facility is on				
		ASA (aspirin) 325 mg p.o. (by				
		(myocardial infarction)				
		be on p.o. or injectable				
		rapy here at GLC (Golden e admission. Most recent				
		s [sic] for post hip fx (fracture)				
		on). Medical hx (history) list				
		atelet or blood clotting factors				
		have increased mental				
		16. Elderly male 96 y.o. (years				
		measurements - posterior L				
		centimeters) L (long) x (by) 12				
		purple and soft. Lateral L				
		0 cm W is a lighter purple, irm areas on either location.				
		e to find a lab report in paper				
		e to find a lab report in paper emplete blood count) or platelet				
		onse: This writer initiated a				
		for communication to lic				
		staff for on-going assessment				
		writer will fax a note re: this				
		ian name] at local clinic. This				

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_	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	0/2010
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
0/0.15	CLIMMA DV CTA		CENT, MN 5		ON	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	5 Continued From page 11		2 265			
	writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).					
	When interviewed of stated when a new identified the charg resident and initiate background, asses. The nurse would the atemporary care pleased in condition RN-A stated a bruist suspicious, would be further stated if bruor if a larger bruise origin was identified also be reported to the 8/10/16 progress pertaining to R38's confirmed the residuleft upper arm that the elbow. RN-A stof bruising but then bruising was unusus stated she should hand notified the phynot been done. RN had not been passed investigated for possioners.	on 8/24/16, at 4:16 p.m. RN-A skin condition for a resident is e nurse would assess the an SBAR (situation, sment, recommendation) note. en notify the physician, create lan, and pass on the resident's in report to the next shift. Se of unknown origin, if the reported to the state. RN-A dising was occurring frequently or hematoma of unknown of and not explainable it would the state. Surveyor reviewed as note written by RN-A left arm bruising. RN-A ent had large bruising to the extended from the shoulder to ated the resident had a history verified that amount of all for the resident. RN-A have completed an SBAR note resident and confirmed that had large on to the next shift, sible causes nor reported to the next shift, said the resident is not a sible cause in the bruising was identified.				
	director of nursing (issue was identified the source of the sk complete an SBAR	on 8/26/16, at 8:46 a.m. the (DON) stated when a new skin I the nurse should investigate kin issue, notify the physician, note, and add the skin issue oblem list to pass on to the				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
			CENT, MN 5			
(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
2 265	next shift. Nursing let the charge nurse identify a new skin of measured though in measure again, but the bruising was get were measured were unless there was a further stated if a later unknown origin was expect it to be repode DON stated she was bruising first identifict subsequently on 8/r prone to bruising as to admission to the many bruises upon R38's medical recowas not admitted wo confirmed the large origin to R38's left assessed with compreported to the physician assessed with compresented to the physician, nurse proposed included: The centrophysician, nurse proposed in the state of the physician, nurse proposed in the physician proposed in the physician phy	assistants (NA's) are also to e know as soon as they concern. Bruises are initially ursing wouldn't necessarily would monitor and indicate if tting better or worse; wounds ekly - bruises not necessarily significant change. DON rge or suspicious bruise of a not explainable, she would rted immediately to the state. Is unaware of R38's left arm	2 265			
	Administrator or des	THOD OF CORRECTION: The signee could review and/or procedures related to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00026	B WING	B. WING		06/0016
NAME OF F	PROVIDER OR SUPPLIER	00936		STATE, ZIP CODE	08/2	26/2016
	LIVINGCENTER - LA	101 SOUT	H HILL STR			
		LA CRESC	CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 13	2 265			
	in resident status a changes. The Qua could conduct audit	cian with significant changes nd educate staff related to the lity Assurance Committee ts periodically for compliance. R CORRECTION: Fourteen				
2 565	. , ,	5 Subp. 3 Comprehensive	2 565			9/23/16
		omprehensive plan of care I personnel involved in the i.				
	by: Based on observati review the facility farelated to transfers R14) that resulted i resident was lowere spiral femur fractur follow the care plan (ADL's) for 1 of 3 re monitor bruising for	ent is not met as evidenced ion, interview and document ailed to follow the care plan for 2 of 3 residents (R9 & n actual harm for R9 when the ed to the floor and sustained a e. The facility also failed to for activities of daily living esidents (R12), and failed to 1 of 1 resident (R38) s of unknown origin.		Corrected		
	Findings include:					
	admission record io	n 11/11/13. Review of R9's dentified diagnoses including oporosis without a current e.				
	R9's Minimum Data	a Set (MDS) significant change				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5				
(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	
2 565	assessment dated Interview for Menta severe cognitive im Assessment (CAA) and fall related injurassistance of 2 staff Review of R9's care identified R9 had pl ADL(activities of dainterventions to incl assist of one staff as needed (PRN). Finterdisciplinary residentified ADL's includentified from the EZ statransfers. Review of R9's nurs 9:54 p.m. identified from the commode and slid down on the incident report date (interdisciplinary tear recommendations, intervention of 1 astransfers was not for Education was proven R9 would remain an Further review of the transferred to the horacture of the right. During interview on assistant (NA)-H stated while she was stated while sh	5/18/16, identified a Brief I Status score of 00 indicating pairment. The Care Area identified R9 at risk for falls ries and the need for extensive if with transfers. It plan, revised 3/25/16, hysical functioning illy living) deficit with ude R9 should have transfer and EZ stand lift or use 2 staff Review of the quarterly ident review dated 8/15/16, huded transfers with the use of fied nursing assistant (NA) d 8/23/16, identified R9 and 1 staff assist for sing notes dated 8/21/16, at R9 was being transferred to the bed with a transfer belt e floor next to her bed. The d 8/21/16, under the IDT am) review and identified the care plan sist w/ (with) EZ stand for bllowed at the time of the fall. Wided to the NA assisting R9. In EZ stand for transfers. In e nurses notes identified R9 ospital 8/23/16 with a spiral	2 565				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00936	B. WING		08/	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DDRESS, CITY, S' TH HILL STRE SCENT, MN 55	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	the commode as shall be stated staff were sulfit to transfer R9. It transfer belt at time commode or wheel stated she was awas supposed to be use NA-H stated, "I screw When asked if ther used the transfer be stated both lifts were short-staffed. During interview with (DON) on 8/23/16, NA-H did not follow the cathought she could jusince R9 was right R9's foot got caugh was turning her and NA-H. On 8/23/16, at 8:35 transferred with a few 18/23/16, at 9:30 a. In pain in her right this having a large hem and movement. R9 was transferred on 8/23/16. A note (ER) visit dated 8/2 R9's right leg was serotated. A note from	ge 15 The was turning her and R9, slid her to the floor." NA-H apposed to use the EZ stand NA-H stated she used the set to transfer R59 between the chair and the bed. NA-H also are the EZ stand was ed for R9 when transferring. Ewed up big by not using it." e was any special reason she selt and not the stand NA-H she se in use and they were The the director of nursing at 3:12 p.m., the DON verified of R9's care plan for transfers. 8/25/16, at 11:53 a.m. 11:53 a.m. 12:59 urse (LPN)-B verified NA-H are plan. NA-H stated she ust transfer R9 with the belt by the bed. NA-H then stated at on the commode when she ded R9 fell in a direction towards. 13:40 a.m. a note identified R9 was all body lift. A note from an identified R9 was having gh with the area being swollen, atoma and tender to touch. 15:50 a.m. from the emergency room 3/16, at 11:07 a.m. identified shortened and externally m 8/23/16, at 13:06 (1:06 p.m.) and that R9's physician had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	ACBESCENT	TH HILL STR CENT, MN 5			
(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
2 565	contacted the facilita a spiral fracture of note from the hosp (4:02 p.m.) identified fracture. The note it to skin and R9 demindicators of pain a femur/hip area. During observation p.m. R12 was obseigaged fingernails wunderneath on both nails were long and to have her nails cu 8/24/16, at 10:25 a bed. During the observation and stanails cut and that sisometime later in the p.m. R12's nails rewith the black/browleft thumb. R12 staroom to cut her nail they would. On 8/2 observed in her rocigaged and dirty wit still present on the	age 16 By and stated R9 had sustained the right femur. An admission ital dated 8/23/16, at 16:02 d R9 had a severe right femur indicated can see femur close constrated non- verbal and had a very swollen right of cares on 8/22/16, at 4:58 erved in her room with long, with dark brown substance in hands. R12 confirmed her is soiled and stated she needed at as they were too long. On i.m. R12 was observed lying in servation R12 was noted to ing, jagged fingernails that eath. R12 was further noted in substance on her left thumb atterviewed during the ated she needed to have her taff were going to do it in the day. On 8/24/16, at 4:00 mained long, jagged and dirty in substance remaining on the lated, staff had not come to her its and she wasn't sure when its and she	2 565			
	them cut. R12's quarterly mir assessment dated Interview for Menta score of 11 indications.	nimum data set (MDS) 8/10/16, included a Brief I Status (BIMS) assessment ing moderate cognitive IDS also identified that R12				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED	
		00936	B. WING		08/	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DDRESS, CITY, S' TH HILL STRE SCENT, MN 55	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	required extensive hygiene. Review of R12's cuidentified R12 received and that was to be remoted for the facilit reviewed 12/7/15, in PROCEDURE: 14.	assistance with personal rrent resident care sheet ved a weekly bed bath on d had a splint to the left hand oved daily for hygiene. Review dule for 8/19/16, indicated R12 n. The bath schedule to PLEASE REMEMBER TO he care plan revised 8/24/16, ired assistance of one staff ne and nail care as needed ad an order to remove her n.M. with cares and complete n was indicated on the order 8/1/16-8/31/16. on 8/25/16, at 10:58 a.m. NA)-A stated R12 got a bed distaff were supposed to do ed at times the nail cares did se she received a bed bath h. NA-A verified it did not look had been completed with her NA-B verified R12's nails and dirty. NA-B stated she m R12's nails right away. I tell my director that they need ed bath too and they don't on 8/25/16, at 11:00 a.m. the 2's care plan was not followed at policy for Bed bath, last				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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 APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 18	2 565			
	dementia, chronic of (COPD), depression per the admission of the admission	num Data Set (MDS) 7/16/16, indicated R14 assistance with toilet use, onal hygiene, and supervision ysical assistance with bed nd locomotion off the unit. It revised 4/4/16, indicated a entions included: "Bed and larms in place and checked ctioning." Review of the assignment sheet identified R14 hair alarm for safety. On 8/24/16, at 3:20 p.m. NA)-D stated R14 required asfers and toileting though sk staff for assistance. NA-D 14 is in bed, she would often e just wanted to rest and not 0 was unsure if the resident nen up in her w/c.				
	in bed crossways a The resident's head the wall with her leg of the bed. R14's v next to the bed by t off; no bed or chair 10:05 a.m., NA-A si	a.m. R14 was observed lying nd appeared to be sleeping. It was positioned up against ps/feet hanging off the exit side w/c was observed positioned he resident's feet with brakes alarm was visualized. At tated R14 had probably into bed. NA-A confirmed an				

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wiinnesc	nta Department of He	ailli	ı			,
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00936	B. WING		08/3	6/2016
		00300			00/2	0/2010
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLDEN	I LIVINGCENTER - LA	CRESCENT 101 SOUT	H HILL STR	EET		
GOLDEN	I LIVINGCENTER - LA	LA CRES	CENT, MN 5	5947		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IOIEIVOT)		
2 565	Continued From pa	ge 19	2 565			
	alarm was not in ni	ace on the chair nor in the bed				
		een. NA-A stated she wasn't				
		dent's hall today but confirmed				
		he resident utilizing a TABS				
		before while up in her w/c.				
		4's room for an alarm but was				
		e; NA-A stated the resident				
		hide or throw away the alarms				
		Iso attempted to reposition the				
	resident in bed but	the resident refused and				
	yelled at NA-A to le	ave her alone. NA-A				
	positioned R14's w/	c next to the bed with the				
		exited the room to alert the				
		f nursing (ADON) that R14				
		ed alarm. Shortly afterwards				
		B entered R14's room with a				
		NA-B attempted to reposition				
		e ADON placed the sensor				
		resident. The ADON was				
		ensor alarm underneath the				
		4 continued to refuse				
		3 stated the resident had				
		res earlier though was unsure				
		ne resident in getting up for the				
	•	ure if R14 had utilized an				
		B searched R14's room and e an alarm. The ADON				
		ent was to utilize an alarm				
		d in bed per the plan of care.				
	when in her w/c and	in bed per the plan of care.				
	R38 was admitted t	o the facility on 7/19/16 with				
		unspecified fall, acute kidney				
		ion, chronic peripheral venous				
		acular degeneration per the				
	admission record fa					
	R38's 14-day admis	ssion data set (MDS) included				
		mental status (BIMS) score of				
		rate cognitive impairment.				
		dicated R38 required total				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN L	IVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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
delopo8sodfil Rarec Finitarefibre en nir (le Finitarefibre)	extensive assistance occomotion on/off undersonal hygiene. In a serious faltered skin integrations and integration in the serious faltered skin integration. Most infection such as discharge, odor, not indings. Skin assestiving Center Policy Review of the Weet and 8/23/16 indicate eviews did not included the following from shoulder esident denies paintly lift for transfers both bladder and stance of notificate aursing staff. A substitute by RN-A dated included: "Did requisioned in the progress note of the pro	ansfers and bathing, and be with bed mobility, nit, dressing, toilet use, and The care plan included a focus grity non pressure initiated as included: Conduct weekly onitor for signs and symptoms a swelling, redness, warm, tify physician of significant essment to be completed per y. kly Skin Reviews dated 8/9/16 ed: Skin Intact. The skin ude evidence of other skin				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR				
		LA CRESO	CENT, MN 5				
(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 APPROFILE DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From page 21		2 565				
	shoulder to L elbow on lateral L thoracic body that appear to on admission asses. There is a brief not dated 8/10/16 @ (a bruise from shoulde Background: Last fa 7/29/16. Res. is on mouth) daily for MI prevention, has not anticoagulation there Living Center) since admission here has rehab. (rehabilitation does not include pla pathology. Noted to confusion on 8/16/10 old). Assessment: upper arm, 28 cm (cm W (wide) is dk. thoracic 8 cm L x 10 soft. No palpable fi This writer is unable chart re: a CBC (co count result. Responsable for the country of the coun	and a smaller bruised area area of res.'s (resident's) be new and were not present sment paper form 7/19/16. The ation in a Gen. (general) Note at the color of the area of the action in a Gen. (general) Note at the at this facility is on ASA (aspirin) 325 mg p.o. (by (myocardial infarction) be on p.o. or injectable appy here at GLC (Golden admission. Most recent a [sic] for post hip fx (fracture) and Medical hx (history) list atelet or blood clotting factors to have increased mental atelet or blood clotting factors to have increased mental and action in the continuation of the continuation in the paper mplete blood count) or platelet on set. This writer initiated a for communication to lice the first on-going assessment writer will fax a note re: this an name] at local clinic. This					
	stated when a new identified the charge resident and initiate	on 8/24/16, at 4:16 p.m. RN-A skin condition for a resident is a nurse would assess the an SBAR (situation, sment, recommendation) note.					

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winnesc	ita Department of He	ailli				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00936	B. WING		08/2	6/2016
					1 00/2	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
		LA CRESO	CENT, MN 5	5947		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG	THE GOESTI OTTE		IAG	DEFICIENCY)		
0.505	0 " 15		0.505			
2 565	Continued From pa	ge 22	2 565			
	The nurse would th	en notify the physician, create				
		lan, and pass on the resident's				
		in report to the next shift.				
		se of unknown origin, if				
		be reported to the state. RN-A				
		ising was occurring frequently				
	or if a larger bruise	or hematoma of unknown				
	origin was identified	d and not explainable would				
		the state. Surveyor reviewed				
	the 8/10/16 progress note written by RN-A					
		left arm bruising. RN-A				
		ent had large bruising to the				
		extended from the shoulder to				
		ated the resident had a history				
		did verify that this amount of				
		al for the resident. RN-A				
		nave completed an SBAR note				
		vsician and confirmed that had				
		I-A further verified the bruising				
		ed on to the next shift,				
		ssible causes nor reported to				
	the state agency wi	nen identified on 8/10/16.				
	When interviewed	on 8/26/16, at 8:46 a.m. the				
		us unaware of R38's left arm				
	bruising first identifi					
		17/16. DON stated R38 was				
		s had fallen many times prior				
		facility and was identified with				
		admission. DON reviewed				
		rd and confirmed the resident				
		ith the left arm bruising. DON				
		area of bruising of unknown				
		arm should have been				
		pletion of an SBAR note, and				
		sician per the plan of care				
	when first identified					
	SUGGESTED MET	HOD FOR CORRECTION:				
	The director of nurs	sing (DON) or designee could				

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STATEMENT OF DEFICIENCIES (X1)

_	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00936	B. WING		08/2	6/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 23	2 565			
	followed. The DON	sure resident care plans are I or designee could then nsure compliance to resident				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			9/23/16
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on observative review the facility faprovide the necess 3 residents (R9) in sustained a femur factual harm, signification facility's failure to a care in a timely material facility failed to provide to 1 of 1 residents.	ent is not met as evidenced ion, interview and document ailed to assess for pain and ary care and services for 1 of the sample who fell and racture which resulted in cant pain to R9, due to the ssess and provide medical nner as required. Also the vide non pressure related skin ent (R38) who had bruising of a failed to ensure services		Corrected		

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING	·····	08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S T H HILL STR	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	CENT, MN 5			
(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
2 830	Continued From pa	age 24	2 830			
		with the hospice agency for 1 of eceiving hospice care.				
	Findings include:					
		nission record identified dementia and osteoporosis nological fracture.				
	in her room in her with moaning. An interv	on 8/22/16, at 5:24 p.m. sitting wheelchair restless and view was attempted about her noaning but R9 was unable to ely to questions.				
	assessment dated Brief Interview for M 00 indicating R9 ha impairment. The C associated with the for falls and fall rela	ange Minimum Data Set (MDS) 5/18/16, identified R9 with a Mental Status (BIMS) score of a severe cognitive are Area Assessment (CAA) MDS identified R9 was at risk ated injuries and required ce of 2 staff with transfers.				
	identified a physica daily living)/deficit v transfers with assis (mechanical lift) or Review of the quarreview dated 8/15/1 assistance includin certified nursing as	e plan revised 3/25/16, Il functioning ADL (activities of with interventions that included at of one staff and EZ stand lift use 2 staff PRN (as needed). It is interdisciplinary resident 16, identified R9 required ADL g transfers with stand lift. The sistant (NA) care sheet lentified R9 requiring the EZ for transfers.				
	During review of the entries were noted:	e nurses notes the following				
	On 8/21/16, at 9:54	p.m. the note identified a				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
(VA) ID	CHMMA DV CTA	TEMENT OF DEFICIENCIES	CENT, MN 5	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMONI OF DEFICIENCIES 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
2 830	Continued From pa	ge 25	2 830			
	was documented in transferred from the transfer belt and sli bed. The note furth right side and that f on her right upper b	n situation had occurred. It the note that R9 was being e commode to the bed with a d down on the floor next to her her identified minimal pain to R9 had reddish colored bruises back under her right arm. The R9 stated she had pain "all				
	had complained of	a.m. a note identified that R9 right thigh pain at 6:00 a.m., stand and required staff to use R9.				
	complaining of pain	p.m. a note identified R9 was to her right thigh while Z stand (mechanical lift				
	was having marked to utilize the EZ stat transfer safely. The lift was used to transbedtime. R9 was n (cm) red scrape be outer aspect of her the note at 11:27 p. the right not the left had a large light pu was raised and stat around the entire how was identified as be measured 6 cm by area was warm to tin pain with use of tin gently in bed.	28 p.m. a note identified R9 I weakness when attempting nd and was not able to e note further indicated a full after R9 back to bed at oted to have a 6 centimeter low her left rib cage, on the left chest. An addendum to m. clarified the scrape was on the note also identified R9 rple hematoma (bruise) that if were able to cup their palmematoma, The hematoma eing firm to touch and 12 cm. R9's upper trochanter ouch. R9 was noticed to wince the lift as well as when rolled				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
	00936		B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 557-	
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
0/4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	CENT, MN 5	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(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
2 830	Continued From pa	ge 26	2 830			
	8/23/16, at 9:30 a.n pain in her right thig	ull body lift. A note from n. identified R9 was having gh with the area being swollen, atoma and tender to touch				
	on 8/23/16. A note of (ER) dated 8/23/16 right leg was shorted note from 8/23/16, ER identified that Report the facility and state fracture of the right from the hospital dap.m.) identified R9 h fracture. The note in to skin and R9 dem	to the hospital at 10:50 a.m. from the emergency room, at 11:07 a.m. identified R9's ened and externally rotated. A at 13:06 (1:06 p.m.) from the 19's physician had contacted ed R9 had sustained a spiral femur. An admission note ated 8/23/16, at 16:02 (4:02 had a severe right femur ndicated can see femur close ionstrated non- verbal and had a very swollen right				
	assistant (NA)-I sta morning. NA-I state stated when she tra that day she used a	8/23/16, at 11:01 a.m. nursing ted she did not get R9 up that ed night shift got R9 up. NA-H ansferred R9 to the wheel chair a full body lift rather than the s sore on the right side.				
	stated R9 utilized a the instructions to u	8/23/16, at 2:25 p.m. NA-J n EZ stand lift. NA-J stated use the EZ stand lift was a care sheet that the aides				
	stated she was wor 8/22/16. NA-D stat up out of her recline leaning way to the I	8/23/16, at 2:32 p.m., NA-D king the evening shift on ed when she went to get R9 er with the EZ lift, R9 was eft putting all of her weight on was not usual for R9. NA-D				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	stated R9 could not pain. NA-D stated nurse immediately. went in to put R9 to again attempted to not put any weight of pale and weak. NA-body lift to get R9 in again told the nurse nurse then went to signs (vs). During interview on assistant director of when R9 was unab going from an EZ listituation should have warranted further in stated, "This would condition for [R9] at reassessed." The mot aware of R9's of to send her to the homography of the best transfer belt. During caught on the commuturn to get resident and NA-H slid R9 to grabbed her right less that NA-H slid R9 to grabbed her right less that NA-H slid R9 to grabbed her right less that NA-H slid R9 to grabbed her right less that NA-C stated that NA-C	stand and was wincing with at that time she notified the NA-D stated that when she bed later that evening she use the EZ lift and R9 would on her right leg and was very D stated staff then used a full not bed. NA-D stated she of R9's condition and the check on R9 and took vital 8/24/16, at 11:21 a.m. the finursing (ADON) stated that le to transfer her typical way, fit to a full body lift, the we been looked into and evestigation. The ADON be considered a change of and she should have been ADON further stated she was ondition until they were going	2 830			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00936	B. WING	·····	08/2	26/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LA CRESCENT STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947						
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	complaining of her During interview on stated she had wor RN-A stated she was transferring poorly of the aides didn't feel EZ stand lift. RN-A look at R9 which she which were fine. R grimacing and appear when she was assistated, at around 10 leg was "out of synchematoma on R9's on her side. RN-A while staff were turn weaker and having she did not check to than the other but of the night shift her fill During interview on stated she had wor NA-K stated it was R9 had an incident stated R9's leg was asked for a pain me stated when she we with the EZ lift, R9 pain and could not nurse went in and gestated she was goir morning. NA-K stated she was goir morning.	leg hurting. 8/24/16, at 2:55 p.m. RN-A ked the evening of 8/22/16. as told in report that R9 was during the day. RN-A stated safe transferring R9 with the stated staff asked her to go le did and she took R9's VS N-A further stated R9 was eared to be in a lot of pain sted into bed. RN-A also 0:00 p.m. she notice R9's right c" and she noted the "huge" thigh and the "huge" scrape stated R9 had facial grimaces ning her stating, "She was a lot of pain.". RN-A stated of see if one leg was shorter locumented and reported off to	2 830			

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Minnesota Department of Health STATE FORM

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE SURVE COMPLETED	
		00936	B. WING		08/2	26/2016
	VIDER OR SUPPLIER	CRESCENT 101 SO	ADDRESS, CITY, JTH HILL STF SCENT, MN 5		·	
(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) COMPLETE DATE
Starol and we part of the part	lled over. NA-L also de painful with more rolled her she grain." uring interview on ated she had world A-A stated R9 was buld not open her alled which would ated she used the are plan indicated. In with the transferse. NA-A stated armal, was not trained at the area of	ed of pain when she was so stated R9's leg was swolled wement and stated, "Anytime rimaced and complained of 8/25/16, at 9:37 a.m. NA-A ked the day shift 8/22/16. It is very restless and tired and eyes when her name was be unusual for R9. NA-A is EZ stand as that is what the it. NA-A stated R9 had a lot of it is which was reported to the R9 was different than her insferring well and kept bain. 8/25/16, at 11:30 a.m. R9's it is transferred on 8/23/16. It is transferred on 8/23/16. It is watch." FA-A stated she has ar mother's right leg and the dout that the femur was and it was over-lapping 3 it is a stransferred, "How did they foot was sideways and 3 on't know how they could ever	d n 3			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

A. BUILDING: COMPLETED 00936 B. WING 08/26/2016	
00930 — 100/20/2010	
	/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN LIVINGCENTER - LA CRESCENT 101 SOUTH HILL STREET LA CRESCENT, MN 55947	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	(X5) COMPLETE DATE
extremity and stated, "She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. NA-D stated she gave R9 Tylenol in the morning before she got up. During interview with the ADON on 8/24/16, at 11: 21 a.m. the ADON verified the physician should have been notified sooner of R9's increased pain and inability to transfer. The ADON verified the documentation identified R9 had been demonstrating pain, had swelling of her leg, and was restless from 8/21/16 to 8/23/16. The facility policy "Notification of Change in Resident Health Status" last reviewed 11/11/15, identified the facility would consult the residents physician, nurse practitioner or physician assistant when there was: (A) An accident which results in injury and had the potential for requiring physician intervention." R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, arrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet. R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total dependence with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00936	B. WING		08/2	6/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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
	skin inspection. Mo of infection such as discharge, odor, no findings. Skin asset Living Center Policy. Review of the Wee and 8/23/16 indicate reviews did not included the following arm from shoulder resident denies pair full lift for transfers both bladder and standarder the following staff. A substance of notifica nursing staff. A substance of notifica nursing staff. A substance of sleep) for leffective." Further review of R include evidence of progress note dated The progress note dated The progress note Change of Condition CNAs (certified nur (large) dk. (dark) pushoulder to L elbow on lateral L thoracid body that appear to	ns included: Conduct weekly conitor for signs and symptoms as swelling, redness, warm, tify physician of significant essment to be completed per y. kly Skin Reviews dated 8/9/16 ed: Skin Intact. The skin ude evidence of other skin	2 830			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	dated 8/10/16 @ (a bruise from shoulded Background: Last from 7/29/16. Res. is on mouth) daily for MI prevention, has not anticoagulation the Living Center) since admission here has rehab. (rehabilitation does not include play pathology. Noted the confusion on 8/16/10 old). Assessment: upper arm, 28 cm (cm W (wide) is dk. thoracic 8 cm L x 1 soft. No palpable from this writer is unable chart re: a CBC (co count result. Responder (licensed) nursing sand charting. This issue to Dr. [physic writer is not certain occurrence due to 10 General Note/Prograre). Further review of the dated 8/17/16 and 8 R38's left upper arm The medical record the bruising after 8/18 Review of electronic mouths of the dated 8/17/16 and 8 R38's left upper arm The medical record the bruising after 8/18 Review of electronic mouths of the dated 8/17/16 and 8 R38's left upper arm The medical record the bruising after 8/18 Review of electronic mouths of the dated 8/17/16 and 8 R38's left upper arm The medical record the bruising after 8/18 Review of electronic mouths of the dated 8/17/16 and 8 R38's left upper arm The medical record the bruising after 8/18 Review of electronic mouths of the dated 8/17/16 and 8 R38's left upper arm The medical record the bruising after 8/18 Review of electronic mouths of the dated 8/17/16 and 8/18/18/18/18/18/18/18/18/18/18/18/18/18	at) 2325 re: a L upper arm er to elbow, no measurement. all here at this facility is on ASA (aspirin) 325 mg p.o. (by (myocardial infarction) be on p.o. or injectable rapy here at GLC (Golden e admission. Most recent [sic] for post hip fx (fracture) n). Medical hx (history) list atelet or blood clotting factors o have increased mental 6. Elderly male 96 y.o. (years measurements - posterior L centimeters) L (long) x (by) 12 purple and soft. Lateral L 0 cm W is a lighter purple, rm areas on either location. This writer initiated a n for communication to lic staff for on-going assessment writer will fax a note re: this ian name] at local clinic. This that bruising is new the notation in the 8/10/16 ress Notes in PCC (point click on and left thoracic bruising. I did not include monitoring of 18/16.	2 830			

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Minnesota Department of Health STATE FORM

PRINTED: 09/26/2016 FORM APPROVED

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		00936	B. WING		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	A C:RESCENT	TH HILL STR			
GOLDLI	LIVINGOEITIER E	LA CRES	CENT, MN 5	5947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 33 on 8/24/16, at 4:16 p.m. RN-A	2 830			
		skin condition for a resident is				
		ge nurse would assess the				
		e an SBAR (situation,				
		ssment, recommendation) note nen notify the physician, create				
		lan, and pass on the resident's				
	change in condition	n in report to the next shift.				
		the 8/10/16 progress note				
		rtaining to R38's left arm firmed the resident had large				
		upper arm that extended from				
		elbow. RN-A stated the				
		ory of bruising but verified that				
		sing was unusual for the				
		ted she should have R note and notified the				
		irmed that had not been done.				
	RN-A further verifie	ed the bruising had not been				
		ext shift nor investigated for				
	possible causes wr	hen identified on 8/10/16.				
	When interviewed	on 8/26/16, at 8:46 a.m. the				
	director of nursing	(DON) stated when a new skin				
		he nurse should investigate the	•			
		issue, notify the physician, I note, and add the skin issue				
		roblem list to pass on to the				
		assistants (NA's) are also to				
		e know as soon as they				
		concern. Bruises are initially				
		nursing wouldn't necessarily t would monitor and indicate if				
		etting better or worse; wounds				
		eekly - bruises not necessarily				
	unless there was a	significant change. DON				
		aware of R38's left arm				
	bruising first identif					
		17/16. DON stated R38 was s had fallen many times prior				

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A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00936 B. WING 08/2	26/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HILL STREET LA CRESCENT, MN 55947		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing. On 8/26/16, at 9:19 a.m. surveyor and DON observed R38 seated in w/c in room with 2 male visitors. DON attempted to remove R38's left arm from his long sleeve shirt but resident became resistive and thus attempt was stopped. Surveyor and DON were able to visualize a portion of the left arm bruising from below R38's left shoulder to the mid upper arm; dark reddish purple bruising noted that surrounded the posterior portion of the resident's upper arm and continued to extend towards the elbow. DON confirmed the bruising continued to be significant and would reattempts to visualize and measure the bruising at a later time. When interviewed on 8/26/16, at 9:37 a.m. the DON reviewed the nursing temporary problem communication book which identified R38's bruising dated 8/17/16. The form indicated that the shift responsible for documentation indicated "all". DON stated with this communication tool the expectation was that nursing would be monitoring and making a chart note daily related to the staus of the bruising until healed. DON confirmed R38's bruising had not been monitored daily per the progress notes nor had been added		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 35	2 830				
	provided measurer bruising; left poster measured 28 centil wide. The bruising measurement on 8						
	A policy on skin wa	s requested but not provided.					
	(MDS) assessment required total staff	hange Minimum Data Set t dated 5/18/16 indicated she assistance in activities of daily erate cognitive impairment.					
	received hospice of coordinate the care family informed of o	ted 6/2/16, identified that R28 entered care and staff were to e plan with Hospice, keep the change in condition and to my change in condition or s.					
	goal of pain manag	plan dated 5/18/16 indicated a gement with weekly and as and social work visits every 6 ded.					
	R28 was sitting up	ion on 8/24/16, at 9:07 a.m. in her recliner chair eating her s alert, neatly dressed and ble.					
	indicated she had r	on 8/24/16, at 9:25 a.m. R28 not been on hospice care for ow when they would be					
	licensed practical n	on 8/24/16, at 9:30 a.m. urse (LPN)-A indicated if there of the norm she would talk to					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00936	B. WING		08/2	6/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	A CRESCENT	TH HILL STR CENT, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 36	2 830				
	the ADON and she hospice. LPN-A fur	would assess whether to call ther indicated hospice visits e did not know when they					
	assistant director o there was no conta and when to contac the bulletin board in further verified they	on 8/24/16, at 9:51 a.m. the finursing (ADON) verified act information regarding how at hospice in R28"s chart or on the nursing office. She odd not know when hospice had asked for a schedule in not provided one.					
	p.m. the triage hos would bring out cor "They had to have verified that hospic the day of the visit changes within the	erview on 8/24/16, at 12:12 pice nurse indicated they ntact information and stated, removed it". She further e would notify the facility on as there are patient schedule organization from day to day. dicated they tried to see R28					
	administrator indication hospice to let them often the hospice wisit. She stated, "V	n 8/24/16, at 3:44 p.m. the ated that she would expect the know of the schedule and would call the morning of the Ve do not have conversations is we see them. They have lost					
	director of nursing expect a visit scheon hospice organization there were no contact	n 8/24/16, at 3:51 p.m. the (DON) indicated she would dule be provided by the on. In addition the DON verified act numbers for hospice t or in the nursing office should contacted.					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
		LA CRESC	CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 37	2 830			
	A hospice policy was requested from the facility but was not provided.					
	document review the services in a manner 3 residents (R9 & Fidentified at risk for to provide services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained to provide the services harm to R9 who sustained the services h	on observation, interview and the facility failed to provide that promoted safety for 2 of R14) in the sample who were falls. The failure of the facility in a safe manner resulted in stained a right femur fracture.				
		nission record identified g dementia and osteoporosis nological fracture.				
	in her room in her w moaning. An interv	on 8/22/16, at 5:24 p.m. sitting wheelchair restless and riew was attempted about her loaning but R9 was unable to ely to questions.				
	assessment dated: Brief Interview for N 00 indicating R9 ha impairment. The C associated with the for falls and fall rela	Inge Minimum Data Set (MDS) 5/18/16, identified R9 with a Mental Status (BIMS) score of d severe cognitive are Area Assessment (CAA) MDS identified R9 was at risk ated injuries and required se of 2 staff with transfers.				
	identified a physica interventions that in one staff and EZ staneeded). Review of resident review date required ADL assist stand lift. The certicare sheet updated	e plan revised 3/25/16, I functioning ADL/deficit with acluded transfers with assist of and lift or use 2 staff PRN (as the quarterly interdisciplinary ed 8/15/16, identified R9 tance including transfers with fied nursing assistant (NA) 8/23/16, identified R9 and and 1 assist for transfers.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING.			
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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
2 830	Continued From pa	ge 38	2 830			
	During review of the entries were noted:	e nurses notes the following				
	change of condition was documented in transferred from the transfer belt and sli bed. The note furth right side and that Fon her right upper be	p.m. the note identified a situation had occurred. It is the note that R9 was being ecommode to the bed with a d down on the floor next to her ner identified minimal pain to R9 had reddish colored bruises back under her right arm. The R9 stated she had pain "all				
	had complained of	a.m. a note identified that R9 right thigh pain at 6:00 a.m., stand and required staff to use R9.				
	complaining of pain	p.m. a note identified R9 was to her right thigh while Z stand (mechanical lift				
	was having marked to utilize the EZ stat transfer safely. The lift was used to get R9 was noted to has crape below her left chest. An adder p.m. clarified the soleft. The note also in purple hematoma (staff were able to chematoma, The hebeing firm to touch	28 p.m. a note identified R9 I weakness when attempting nd and was not able to e note further indicated a full R9 back to bed at bedtime. Eve a 6 centimeter (cm) red eft rib cage, on outer aspect of and to the note on 11:27 crape was on the right not the dentified R9 had a large light bruise) that was raised and up their palm around the entire ematoma was identified as and measured 6 cm by 12 cm. ter area was warm to touch.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		0,1010
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	DENT, MN 5	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 39	2 830			
	R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed.					
	was transferred wit 8/23/16, at 9:30 a.n pain in her right thig	a.m. R9 a note identified R9 h a full body lift. A note from n. identified R9 was having gh with the area being swollen, atoma and tender to touch				
	A note from the em 8/23/16, at 11:07 a. shortened and exte 8/23/16, at 13:06 (1 identified that R9's facility and stated F fracture of the right from the hospital dap.m.) identified R9 fracture. The note i to skin and R9 dem	to the hospital at 10:50 a.m.,. ergency room (ER) dated m. identified R9's right leg was rnally rotated. A note from :06 p.m.) from the ER physician had contacted the 89 had sustained a spiral femur. An admission note ated 8/23/16, at 16:02 (4:02 had a severe right femur ndicated can see femur close ionstrated non- verbal nd had a very swollen right				
	stated R9 utilized a the instructions to u	8/23/16, at 2:25 p.m. NA-J n EZ stand lift. NA-J stated use the EZ stand lift was a care sheet that the aides				
	stated she was wor 8/22/16. NA-D stat up out of her recline leaning way to the I the left side, which stated R9 could not pain. NA-D stated	8/23/16, at 2:32 p.m., NA-D king the evening shift on ed when she went to get R9 er with the EZ lift, R9 was eft putting all of her weight on was not usual for R9. NA-D at stand and was wincing with at that time she notified the NA-D stated that when she				

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	DATE SURVEY COMPLETED
00936 B. WING	08/26/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN LIVINGCENTER - LA CRESCENT 101 SOUTH HILL STREET LA CRESCENT, MN 55947	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG DEFICIENCY)	(X5) COMPLETE DATE
went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (vs). During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated."This would be considered a change of condition for [R9] and she should have been reassessed." The ADON further stated she was not aware of R9's condition until they were going to send her to the hospital. During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get resident onto the bed, R9 fell into her and NA-H side R9 to the floor. NA-H stated R9 grabbed her right leg and complained of pain. During interview on 8/24/16, at 2:55 p.m. RN-A stated she was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's vital signs, which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LA	A CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	stated, at around 1 leg was "out of synhematoma on R9's on her side. RN-A while staff were tur weaker and having she did not check to than the other but of the night shift her fill. During interview on stated she had wor NA-K stated it was R9 had an incident stated R9's leg was asked for a pain mostated when she wow with the EZ lift, R9 pain and could not nurse went in and of stated she was goin morning. NA-K stated she was goin morning. NA-K stated complained of pain could not bear weig stated,"Her leg hur put pressure on it, During interview on stated she had wor NA-A stated R9 was would not open her called which would stated she used the care plan indicated pain with the transfinurse. NA-A stated normal, was not trarepeating she had increased the care plan indicated pain with the transfinurse. NA-A stated normal, was not trarepeating she had increased the care plan indicated pain with the transfinurse. NA-A stated normal, was not trarepeating she had increased the care plan indicated pain with the transfinurse. NA-A stated normal, was not trarepeating she had increased the care plan indicated pain with the transfinurse. NA-A stated normal, was not trarepeating she had increased the care plan indicated pain with the transfinurse. NA-A stated normal, was not transfinurse.	0:00 p.m. she notice R9's right c" and she noted the "huge" thigh and the "huge" scrape stated R9 had facial grimaces ning her stating, "She was a lot of pain.". RN-A stated o see if one leg was shorter documented and reported off to indings. 1. 8/25/16, at 6:27 a.m. NA-K ked the night of the 8/21/16. not reported to the NA's that on the evening shift. NA-K swollen and sore and R9 ed during the night. NA-K ent to get R9 up in the morning was crying and moaning in transfer NA-K stated the gave R9 a pain medication and ing to look at R9's leg in the ted when she sat R9 up R9 and started moaning and ght on her right leg. NA-K treally bad and she wouldn't it was swollen at that time." 1. 8/25/16, at 9:37 a.m. NA-A ked the day shift 8/22/16. It was svery restless and tired and reyes when her name was be unusual for R9. NA-A et EZ stand as that is what the last swhich was reported to the R9 was different than her unsferring well and kept	2 830			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DDRESS, CITY, S TH HILL STR CENT, MN 5			
(X4) ID 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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	daughter (FA)-A state when her mother w FA-A stated her mo was "excruciating to seen the x-ray of he surgeon had pointed broken at an angle inches. The daugh not notice this, Her inches shorter? I do try to stand her up!" During interview on stated she was on of the floor. LPN-B storuising, did a little think the right leg at During interview on having pain the more R9 may have had nextremity and state fall." RN-D stated fell." RN-D stated fell.	as transferred on 8/23/16. ther was in so much pain it o watch." FA-A stated she had ar mothers right leg and the dout that the femur was and it was over-lapping 3 ter also stated, "How did they foot was sideways and 3 on't know how they could even by the stated she did not notice range of motion and didn't peared to be fractured. 8/25/16, RN-D stated R9 was rning of 8/22/16. RN-D stated range of motion and didn't peared to be fractured. 8/26/16, RN-D stated R9 was rning of 8/22/16. RN-D stated range of motion and didn't peared to be fractured. 8/26/16, RN-D stated R9 was rning of 8/22/16. RN-D stated range of motion and didn't peared to be fractured. 8/26/16, RN-D stated R9 was rning of 8/22/16. RN-D stated range of motion and ster a not be reported R9 had pain and g. RN-D further stated that on to 8/23/16, the NA's reported in her right leg with the stated she gave R9 Tylenol in she got up. Notification of Change in attus" last reviewed 11/11/15, or would consult the residents actitioner or physician re was: (A) An accident which had the potential for requiring				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7.1. 20.25			
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	(COPD), depression per the admission of	obstructive pulmonary disease n, anxiety, and osteoporosis record face sheet. num Data Set (MDS) 7/16/16, indicated R14 assistance with toilet use, onal hygiene, and supervision ysical assistance with bed nd locomotion off the unit. It revised 4/4/16, indicated a entions included: "Bed and larms in place and checked ctioning." Review of the ssignment sheet identified R14 chair alarm for safety. On 8/24/16, at 3:20 p.m. NA)-D stated R14 required asfers and toileting though sk staff for assistance. NA-D 14 is in bed, she would often to was unsure if the resident	2 830			
	On 8/25/16, at 9:53 in bed crossways a The resident's head the wall with her leg of the bed. R14's with next to the bed by toff; no bed or chair 10:05 a.m., NA-A stransferred herself alarm was not in pland should have be	a.m. R14 was observed lying nd appeared to be sleeping. It was positioned up against gs/feet hanging off the exit side w/c was observed positioned he resident's feet with brakes alarm was visualized. At tated R14 had probably into bed. NA-A confirmed an ace on the chair nor in the bed een. NA-A stated she wasn't dent's hall today but confirmed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LA	A CRESCENT	H HILL STR CENT, MN 5			
(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) COMPLETE DATE
2 830	clip alarm the day in NA-A searched R14 unable to locate on had been known to in the past. NA-A a resident in bed but yelled at NA-A to le positioned R14's who brakes locked then assistant director o was in need of a bethe ADON and NA-sensor pad alarm. R14 in bed while the pad underneath the able to place the seresident though R1 repositioning. NA-B was unsalarm earlier. NA-B was unable to locate confirmed the resident though R1 refused morning can who had assisted the day; NA-B was unsalarm earlier. NA-B was unable to locate confirmed the resident though R1 reducate staff to ensigned the resident of nurseducate staff to ensignee could the resident's receive of individualized care	perfore while up in her w/c. 4's room for an alarm but was e; NA-A stated the resident hide or throw away the alarms also attempted to reposition the the resident refused and ave her alone. NA-A /c next to the bed with the exited the room to alert the finursing (ADON) that R14 ed alarm. Shortly afterwards B entered R14's room with a NA-B attempted to reposition e ADON placed the sensor e resident. The ADON was ensor alarm underneath the 4 continued to refuse B stated the resident had ares earlier though was unsure the resident in getting up for the ure if R14 had utilized an B searched R14's room and the an alarm. The ADON lent was to utilize an alarm d in bed per the plan of care. THOD OF CORRECTION: Sing (DON) or designee could soure resident care plans are ewe conditions are assessed, ated as needed. The DON or in perform audits to ensure eare in accordance with their	2 830			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	.0/2010
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
	OLIMANA DV. OTA		CENT, MN 5			0.5
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 45	2 860			
2 860	MN Rule 4658.0520 Proper Nursing Car	Subp. 2 F. Adequate and re; Hands-Feet	2 860			9/23/16
	proper care. The c adequate and prop E. per care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview and document illed to provide nail care for 1) reviewed for activities of daily		Corrected		
	Findings include:					
	p.m. R12 was obse jagged fingernails v underneath on both nails were long and	of cares on 8/22/16, at 4:58 rved in her room with long, with dark brown substance hands. R12 confirmed her soiled and stated she needed at as they were too long.				
	lying in bed. During noted to continue to that were soiled unnoted have a black, thumb cuticle. R12 observation and stanails cut and that stanails cut and	•				
	long, jagged and di	p.m. R12's nails remained rty with the black/brown ng on the left thumb. R12				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5			
(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
2 860	Continued From pa	ge 46	2 860			
	stated, staff had not come to her room to cut her nails and she wasn't sure when they would.					
	her room with nails dirty with the black/ on the left thumb cu	a.m. R12 was observed in remaining long, jagged and brown substance still present uticle. R12 also stated her and she needed them cut.				
	assessment dated Interview for Menta score of 11 indicatir impairment. The M	imum data set (MDS) 8/10/16, included a Brief I Status (BIMS) assessment ng moderate cognitive IDS also identified that R12 assistance with personal				
	identified R12 receil Friday mornings and that was to be remorded to FR9's bath scheduled received a bath identified staff were DO NAIL CARE!! To identified R12 requivitation of R12 also had palm guard in the A	rrent resident care sheet ved a weekly bed bath on d had a splint to the left hand oved daily for hygiene. Review ale for 8/19/16, indicated R12 h. The bath schedule to PLEASE REMEMBER TO the care plan revised 8/24/16, ired assistance of one staff ne and nail care as needed ad an order to remove her a.M. with cares and complete h was indicated on the order 8/1/16-8/31/16.				
	nursing assistant (N bath on Fridays and her nails. She state not get done becau instead of a tub bat like R12's nail care	on 8/25/16, at 10:58 a.m. NA)-A stated R12 got a bed d staff were supposed to do ed at times the nail cares did se she received a bed bath h. NA-A verified it did not look had been completed with her NA-B verified R12's nails				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
			A. BUILDING.				
		00936	B. WING		08/2	6/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETE DATE	
2 860	Continued From pa	age 47	2 860				
	were long, jagged and dirty. NA-B stated she would clean and trim R12's nails right away. NA-B also stated, "I tell my director that they need to do nails with a bed bath too and they don't always do it."						
	When interviewed on 8/25/16, at 11:00 a.m. the director of nursing (DON) confirmed R12 should have had nail care provided per her plan of care. The DON further confirmed the NA's were responsible for nail care when resident's received their bath regardless if a bed bath, shower or tub bath is given.						
	Review of the facility policy for Bed bath, last reviewed 12/7/15, included: PROCEDURE: 14. Care of fingernails and toenails is part of the bath. Be certain nails are clean.						
	The DON should el re-educated as to t dependent resident care according to fa conduct audits to e	THOD FOR CORRECTION: nsure that staff are heir responsibility to provide ts with assistance with nail acility policy. The DON should nsure the care is being ed and take action as needed.					
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			9/23/16	
	maintain a comprel infection control procurrent tuberculosis	e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines id States Centers for Disease					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING	····	08/2	6/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	ADDRESS, CITY, STATE, ZIP CODE UTH HILL STREET ESCENT, MN 55947			
(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
21426	Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volui Health shall provide regarding implemen	tion (CDC), Division of ation, 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.	21426			
	by: Based on interview facility failed to ensi (TB) screening prod employees was cor Centers for Disease (CDC) guidelines for assistant (NA)-E, N have a symptom so skin test (TST) com Findings include: NA-E, hire date of 6 symptom screen ar hire. NA-F, hire date of 7	npleted according to the e Control and Prevention or 3 of 5 employees (nursing NA-F & NA-G) who did not reen and 2 step tuberculin		Corrected		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
			A. BOILDING.	7. BOILDING.			
		00936	B. WING		08/2	6/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR CENT, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ige 49	21426				
	NA-G, hire date of 5/19/16, did not have a symptom screen and 2-step TST completed upon hire.						
	director of nursing	on 8/26/16, at 12:50 p.m. the (DON) confirmed the symptom TSTs had not been completed loyees.					
	director of nursing review policies and components of the monitoring program educated on the TE Mantoux process.	THOD OF CORRECTION: The (DON) and/or designee could procedures related to the infection control and TB n. Facility staff could be 3 regulations and the two step The director of nursing and/or velop a monitoring system to mpliance.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one-					
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610			9/23/16	
	must store all drugs under proper tempe	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have					
	by: Based on observat review, the facility f were appropriately	ent is not met as evidenced ion, interview and document ailed to ensure medications secured at all times during dication pass for 1 of 2		Corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	26/2016
-	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STR CENT, MN 5			
(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
21610	Findings include: R60 had physician insulin aspart, five to meals and insulin a orders indicated that between 150 milligr 200 mg/dL, two additions be administered. During observations 100 wing medication of room 106. Obseregistered nurse (R (same as aspart) in cart drawer, wasted pen to five units and of the medication cart whis sugar. Observation walked away from the 112 located near the RN-A then checked 112. When the blocompleted, RN-A restill positioned outsit Observations at the and two visitors well the medication cart pen, dialed two more and returned to administration. During interview on director of nursing well and not left unattencart.	orders dated 8/12/16, for units to be injected before spart on a sliding scale. The at when R60's blood sugar was ams per deciliter (mg/dL) and ditional units of aspart were to so on 8/24/16, at 5:05 p.m., the n cart was positioned outside revations at that time revealed N)-A removed R60's Novolog sulin pen from the medication at two units of insulin, dialed the diplaced the insulin pen on top art. RN-A stated the routine sulin and leave it on top of the le RN-A checked R60's blood at that time revealed RN-A he medication cart to room e end of the 100 wing hallway. I R60's blood sugar in room od sugar check was eturned to the medication cart,	21610			

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00936	B. WING		08/2	6/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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
21610	Guidelines policy dindicated that, "Dur medications, the mand locked when or nurse or aide. No rethe cart. The cart repersonnel administ outward sides must or others passing by SUGGESTED MET. The director of nurse develop, review, an procedures to ensurappropriately stored nursing (DON) or dispersonate staff or The director of nurse develop monitoring compliance. TIME PERIOD FOR (21) Days. MN St. Statute 144 Residents of HC Fassible. 27. Advisor	paration and General ated 6/2015, page 4 #16 ing administration of edication cart is kept closed at of sight of the medication medications are kept on top of must be clearly visible to the ering medications, and all to be inaccessible to residents y." THOD OF CORRECTION: sing (DON) or designee could ad/or revise policies and irre medications are do and locked. The director of esignee could educate all in the policies and procedures. Sing (DON) or designee could systems to ensure ongoing R CORRECTION: Twenty-one	21610			9/23/16
	maintain, and partic family councils. Ea assistance and spa meetings shall be a visitors attending or invitation. A staff presponsibility of pro- responding to writte	cipate in resident advisory and ach facility shall provide ace for meetings. Council afforded privacy, with staff or any upon the council's erson shall be designated the aviding this assistance and en requests which result from Resident and family councils				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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
21915	Continued From pa	ge 52	21915			
	shall be encourage regarding facility po	d to make recommendations licies.				
	This MN Requirements	ent is not met as evidenced				
	facility failed to atte council on at least a	and document review, the mpt to organize a family an annual basis. This had the Il 37 resident families who		Corrected		
	Findings include:					
	administrator confir an existing family of further confirmed sl	8/23/16, at 10:06 a.m. the med the facility did not have buncil. The administrator he had not formally attempted a council in the past year.				
	administrator or des attempts are made The administrator of	HOD OF CORRECTION: The signee should ensure thorough to develop a family council. It designee should develop to ensure thorough attempts the family council.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vul	.557 Subd. 3 Reporting - nerable Adults	21980			9/23/16
	reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained	f report. (a) A mandated asson to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
		LA CRESC	CENT, MN 5		211	
(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 APPROFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 53	21980			
21980	individual is a vulne the individual is adrreporter is not required maltreatment of the to admission, unless (1) the individual was another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this known or suspected knows or has reason been made to the control (d) Nothing in this reporter from also reason to believe the 626.5572, subdivision (5), occurred must subdivision. If the retime believes that a agency will determine	erable adult solely because mitted to a facility, a mandated ired to report suspected individual that occurred prior is: as admitted to the facility from the reporter has reason to be adult was maltreated in the mows or has reason to believe a vulnerable adult as defined a vulnerable adult as defined a subdivision 21, clause (4). It required to report under the ection may voluntarily report and the section requires a report of dimaltreatment, if the reporter on to know that a report has ommon entry point. It is section shall preclude a reporting to a law enforcement and error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead ne or should determine that	21980			
	the criteria under set 17, paragraph (c), of facility may provided directly to the lead a how the event mee 626.5572, subdivisit (5). The lead ager	vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or to the common entry point or agency information explaining at the criteria under section on 17, paragraph (c), clause acy shall consider this making an initial disposition of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. 50.25.110.			
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LA	A CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	age 54	21980			
	the report under su	bdivision 9c.				
	by: Based on interview facility failed to repeabuse/neglect imm State agency for 1 sustained a spiral f direct result of the	ent is not met as evidenced and document review, the ort an occurrence of possible ediately to the designated of 3 residents (R9) who racture of the right femur as a care plan not being followed, ent (R38) with significant n origin.		Corrected		
	Review of R9's adr	nission record identified g dementia and osteoporosis hological fracture.				
	assessment dated Interview for Menta severe cognitive im Assessment (CAA)	a Set (MDS) significant change 5/18/16, identified a Brief al Status score of 00 indicating apairment. The Care Area identified R9 at risk for falls ries and the need for extensive ff with transfers.				
	identified R9 had p ADL(activities of da interventions that ir transfer assist of or 2 staff as needed (interdisciplinary residentified ADL's inc stand lift. The certicare sheet, updated	e plan revised 3/25/16, hysical functioning ally living) deficit with included R9 should have ne staff and EZ stand lift or use PRN). Review of the quarterly sident review dated 8/15/16, sluded transfers with the use of tified nursing assistant (NA) d 8/23/16, identified R9 and and 1 staff assist for				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016	
NAME OF PROVIDER (R SUPPLIER			STATE, ZIP CODE			
GOLDEN LIVINGO	ENTER - L	A CRESCENT	TH HILL STR CENT, MN 5				
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21980 Continu	ed From pa	age 55	21980				
Review 9:54 p.n from the and slid incident (interdis recomm w/ (with) time of f assistant stand for notes id 8/23/16 During i stated s was low was transfer and the the EZ s when traby not u special if the stan they were composed in the stan the	of R9's numerous identified down on the report date ciplinary terendations, EZ stand all. Educate (NA) assist transfers. The transfer ered to the esferring R9 is right heel turning her to the floored to use the ated she use the tand was substand was su	sing notes dated 8/21/16, at I R9 was being transferred to the bed with a transfer belt ne floor next to her bed. The ed 8/21/16, under the IDT am) review and identified care plan of 1 assist for transfers not followed at tion provided to nursing sting R9. R9 will remain an EZ Further review of the nurses' was transferred to the hospital al fracture of the right femur. 18/24/16, at 3:05 p.m. NA-H red R9 on 8/21/16 when R9 floor. NA-H stated while she between the commode and caught on the commode as r, and R9 "Fell into me and I." NA-H stated staff were the EZ stand lift to transfer R9. Sed the transfer belt at times to the commode or wheelchair I also stated she was aware supposed to be used for R9 NA-H stated "I screwed up big When asked if there was any used the transfer belt and not ted both lifts were in use and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	6/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOU	DRESS, CITY, S FH HILL STR CENT, MN 5			
(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
21980	licensed practical n did not follow the ca had stated she'd the R9 with the belt sine NA-H then stated R the commode wherhad fallen towards I R9's medical record an incident report h State agency until 8 incident occurred, a the hospital and dia The incident report indicated the report reported was negle: R38 was admitted the diagnoses including failure, atrial fibrillat insufficiency, and madmission record faths as 14-day admission record faths as 14-day a	urse (LPN)-B verified NA- Hare plan. LPN-B said NA-Hought she could just transfer to R9 was right by the bed. 9's foot had gotten caught on a she was turning her and R9 NA-H. If documents lacked evidence ad been submitted to the standard results after R9 had been sent to gnosed with a spiral fracture. Submitted on 8/23/16 of maltreatment being ct. To the facility on 7/19/16 with a unspecified fall, acute kidney ion, chronic peripheral venous racular degeneration per the ace sheet. The sion minimum data set (MDS) review for mental status (BIMS) and moderate cognitive DS further indicated R38 cance with transfers and sive assistance with bed a on/off unit, dressing, toilet anygiene. The care plan altered skin integrity, non standard results as warm, discharge, odor, notify warm, discharge, odor, notify				

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PRINTED: 09/26/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S H HILL STR CENT, MN 5			
(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)	LD BE	(X5) COMPLETE DATE
21980	Review of the nursi nurse (RN)-A dated included the followi arm from shoulder resident denies pair full lift for transfers both bladder and st measurements of the evidence of notifical nursing staff. A substance documented by (11:13 p.m.) included needed) Oxycodon upper arm pain, that Further review of R there was no mentinursing progress not (2:42 a.m.). The properties of (1:00 a.m.) CNAs (addiscovered lg. (larguarea on posterior at extending from L strength smaller bruised are res.'s (resident's) bowere not present or paper form 7/19/16 Gen. (general) Note re: a L upper arm be no measurement. It is facility is on 7/2 325 mg p.o. (by moinfarction) prevention injectable anticoagu (Golden Living Cenrecent admission her (fracture) rehab. (recent istory) list does not form the facility is on facture) rehab. (recent admission her (fracture) rehab. (recent admission her (fracture) list does not facture) list does not facture the facture of th	ng progress note by registered 8/10/16, at 23:25 (11:25 p.m.) ng, "Noted bruising on left to elbow. Area soft and not to touch. Continues to need and remains incontinent of col." The note did not include ne left arm bruising nor tion to the physician or other osequent nursing progress y RN-A dated 8/14/16 at 23:13 ed, "Did request prn (as e at hs (hour of sleep) for left	21980			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 58	21980			
	increased mental comale 96 y.o. (years measurements - po (centimeters) L (londk. purple and soft. 10 cm W is a lighter firm areas on either to find a lab report in (complete blood con Response: This wr Problem for communursing staff for oncharting. This write to Dr. [physician nais not certain that be to the notation in the	onfusion on 8/16/16. Elderly old). Assessment: esterior L upper arm, 28 cm eg) x (by) 12 cm W (wide) is Lateral L thoracic 8 cm L x r purple, soft. No palpable r location. This writer is unable n paper chart re: a CBC unt) or platelet count result. eiter initiated a Temporary unication to lic (licensed) egoing assessment and er will fax a note re: this issue me] at local clinic. This writer ruising is new occurrence due				
	dated 8/18/16, com director (ED) includ "Description of ever occurred from an u home) staff conclud outer torso likely occuse for transfers. A nursing indicates by SBAR was completed notification completed Assessment of Resonated resident presoupper arm from show was unknown. SBANOC (night) nurses bruising as well as torso region. Bruismore swollen than open skin found on facility was 7/29/16	nt/allegation: Bruising has nknown cause. NH (nursing de bruising to left arm and left curred from mechanical lift a progress note 8/10 by ruising first noted then. An red 8/17 with family and MD red at that time. Sident: on 8/10 it was first ented with new bruising to left bulder down to elbow, cause AR report was completed by 8/17 in relation to left arm extended bruising to left outer es are dark purple. Left arm is the right. No hematoma or assessment. Last fall in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		0, _ 0
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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)	D BE	(X5) COMPLETE DATE
21980	pan to bruised area cause of bruising a until notified by staft Casual/contributing Resident had a fall is chronically on AS anticoagulation for dependent with all imechanical lift use Resident noted to home confusion since admonitored and dochas very fragile skin Recommendation/ireoccurrence: Mor to CNAs during AD transfers r/t (related anticoagulation me Summary and outo Nursing, resident a exact time, location bruising took place an event. Only know documented fall from Resident was evaluation to k place on 8/17 medication change ordered by MD. "	as. Resident is unable to recall nd was unaware of bruising if. I factors and observations: on 7/29 from bed to floor. He is 325 mg as only MI prevention. Resident is transfers which requires and 1-2 person assist. In ave increased mental mission which is being umented by nursing. Resident in. Interventions taken to prevent e careful handling reinforced Ls and mechanical lift it to fragile skin and	21980			
	a temporary care p change in condition RN-A stated a bruis suspicious, would b	lan, and pass on the resident's in report to the next shift. se of unknown origin, if the reported to the State. RN-A ising was occurring frequently				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER	CRESCENT 101 SOUT	DRESS, CITY, S TH HILL STRI CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	or if a larger bruise origin was identified also be reported to the 8/10/16 progres pertaining to R38's confirmed the resid left upper arm that the elbow. RN-A st of bruising but verif was unusual for the should have complenotified the physicial been done. RN-A from the prossible causes agency when identified the source of the skin is complete an SBAR to the temporary property property and the bruising was get were measured though romeasure again, but the bruising was get were measured we unless there was a further stated if a launknown origin was expect it to be reportationally and the bruising first identification subsequently on 8/prone to bruising as to admission to the	or hematoma of unknown d and not explainable would the state. Surveyor reviewed is note written by RN-A left arm bruising. RN-A ent had large bruising to the extended from the shoulder to ated the resident had a history ited that this amount of bruising itersident. RN-A stated she eted an SBAR note and an and confirmed that had not urther verified the bruising had in to the next shift, investigated in the nurse should investigate the insue, notify the physician, note, and add the skin issue oblem list to pass on to the assistants (NA's) are also to be known as soon as they concern. Bruises are initially investing wouldn't necessarily investigate the result of the state in the state of sonot explainable she would red immediately to the state. Its unaware of R38's left arm				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00936	B. WING		08/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	was not admitted we confirmed the large origin to R38's left a assessed with commended to the phy agency when first is subsequently investing. When interviewed of ED stated after investing and left thoracic bropposably from the fresident. The ED comprobably from the fresident. The ED composable source ED was unaware if using the lift on R33 the investigation into SUGGESTED MET administrator or defeducation and train of staff, to ensure if allegations of abust and reported to the administrator immediated and the resident.	and and confirmed the resident with the left arm bruising. DON area of bruising of unknown arm should have been pletion of an SBAR note, sician, administrator, and state dentified on 8/10/16, and stigated and monitored by on 8/26/16, at 9:04 a.m. the estigating R38's left upper arm uising deemed that it was ull body lift used for this confirmed the facility did not not bruising of unknown origin to rior too or after investigating of the bruising. Further, the f staff had been observed 8 or training provided following to the bruising. THOD OF CORRECTION: The signee could provide ing regarding responsibilities njuries of unknown origin and e are thoroughly investigated	21980			
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen				
22000		3.557 Subd. 14 (a)-(c) atment of Vulnerable Adults	22000			9/23/16
	Subd. 14. Abuse	prevention plans. (a) Each				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
	00936	B. WING		08/2	6/2016
NAME OF PROVIDER OR SUPPLIE	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - I	A CRESCENT	H HILL STR			
OVA ID CLIMMADV C	TATEMENT OF DEFICIENCIES	CENT, MN 5		ON	(X5)
PREFIX (EACH DEFICIEN				(EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DATE:	
22000 Continued From p	Continued From page 62				
facility, except hospersonal care atteestablish and enformation plan. assessment of the environment, and factors which may and a statement of to minimize the riscomply with any repromulgated by the (b) Each facility agency and person providers, shall deprevention plan for residing there or residing the resident to the plan shall consider the resident to the plan the plan must detail the minimize the risk reasonably be explan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded. Under the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the minimize the risk reasonably be explanded to personal care the plan must detail the plan must detai	me health agencies and ndant services providers, shall proce an ongoing written abuse. The plan shall contain an exphysical plant, its its population identifying rencourage or permit abuse, of specific measures to be taken as to abuse. The plan shall alles governing the plan explication licensing agency. Including a home health care nal care attendant services evelop an individual abuse reach vulnerable adult explication and individualized. The person's susceptibility to dividuals, including other (2) the person's risk of abusing dults; and (3) statements of the at person and other vulnerable proses of this paragraph, the	22000			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00936	B. WING	·····	08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
22000	Continued From pa	ge 63	22000			
	another facility, and	a medical record prepared by ther health care provider, or g assessments of the				
	by: Based on interview facility failed to implet the immediate reposit administrator and the for 1 of 3 residents fracture of the right care plan not being (R39) with significal In addition, the policy would constitute mi	and document review the ement their policy related to rting of abuse/neglect to the ne designated State agency (R9) who sustained a spiral femur as a direct result of the followed, and 1 of 1 resident nt bruising of unknown origin. Cy did not clearly define what streatment, abuse, neglect, source or misappropriation of		Corrected		
	Alleged Violations of Involving Mistreatm of Unknown Source Resident's Property following: It is the pappropriate steps to abuse, neglect, injumisappropriation of ensure that all alleg State laws which in abuse, injuries of un misappropriation of	eporting and Investigation of of Federal and State Laws ent, Neglect, Abuse, Injuries and Misappropriation of a dated 7/12/16, included the policy of the Company to take to prevent the occurrence of the of unknown origin and resident property and to red violations of Federal or volve mistreatment, neglect, inknown origin and resident property ("alleged orted immediately to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00936	B. WING		08/26/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	A CIRESCIENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	AND the Director of Aegis employee. See reported to State age existing State law, investigation of each there is a conflict of implicated in the all responsible to repositive to the by state and federal. The policy further in Reporting of susperequired of every ending included: An alleged violation shand DOR if it is an AND DOR shall alsagency, in accordanotify immediate minvestigations must appropriate State a law, within five (5) will without current path. Review of R9's addiagnoses including without current path.	(hereinafter "ED") of the center f Rehabilitation (DOR) if it is such violations will also be gencies in accordance with The ED will direct a thorough the such alleged violation unless f interest or the ED is eged violation, The ED is reged violation, The ED is results of all estate agencies as required allaw. Included under identification: ceted alleged violations is imployee. The esection titled Reporting, the py employee who suspects an all immediately notify the ED on Aegis employee. The ED on notify the appropriate state ince with state law, as well as an agement. The results of all is be reported by the ED to the gency, as required by State working days of the alleged elearly define what would ment, abuse, neglect, injuries or misappropriation of	22000			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	DENT, MN 5	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
22000	Continued From page 65		22000			
	Assessment (CAA) and fall related inju- assistance of 2 staf	e plan revised 3/25/16,				
	ADL(activities of da interventions that in transfer assist of or 2 staff as needed (I interdisciplinary res identified ADL's inc stand lift. The certi care sheet, updated	ily living) deficit with included R9 should have the staff and EZ stand lift or use PRN). Review of the quarterly ident review dated 8/15/16, luded transfers with the use of fied nursing assistant (NA) d 8/23/16, identified R9 and 1 staff assist for				
	9:54 p.m. identified from the commode and slid down on the incident report date (interdisciplinary tear recommendations, w/ (with) EZ stand fitme of fall. Educat R9. R9 will remain Further review of the	identified care plan of 1 assist or transfers not followed at ion provided to NA assisting an EZ stand for transfers. e nurses notes identified R9 ital 8/23/16 with a spiral				
	assistant (NA)-H st 8/21/16 when R9 w stated while she wa the commode and I the commode as sh "Fell into me and I s	8/24/16, at 3:05 p.m. nursing atted she transferred R9 on as lowered to the floor. NA-H as transferring R9 between bed R9's right heel caught on the was turning her and R9, slid her to the floor." NA-H apposed to use the EZ stand				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	SHOULD BE COMPLETE	
22000	lift to transfer R9. It transfer belt at time commode or wheel stated she was awa supposed to be use NA-H stated "I scre When asked if then used the transfer be stated both lifts wer staffed. During interview wit (DON) on 8/23/16, NA-H did not follow and that no report hagency until 8/23/10. During interview on licensed practical in did not follow the cathought she could jusince R9 was right R9's foot got caugh was turning her and NA-H. R9's medical record an incident report wagency until 8/23/10 occurred, and R9 with a spreport submitted on of maltreatment report R38 was admitted the diagnoses including failure, atrial fibrillation.	NA-H stated she used the s to transfer R59 between the chair and the bed. NA-H also are the EZ stand was ed for R9 when transferring. Wed up big by not using it." e was any special reason she elt and not the stand NA-H she er in use and they were short that the director of nursing at 3:12 p.m. the DON verified w R9's care plan for transfers and been filed with the state of the st	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
GOLDE	N LIVINGCENTER - LA	CRESCENT	TH HILL STRI CENT, MN 5			
(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
22000	R38's 14-day admis a brief interview for 12 indicating moder. The MDS further in assistance with trarextensive assistance locomotion on/off upersonal hygiene. of altered skin integ 8/1/16. Intervention skin inspection. Moof infection such as discharge, odor, no findings. Skin asse Living Center Policy. Review of the nursi nurse (RN)-A dated included the following arm from shoulder resident denies painfull lift for transfers both bladder and st measurements of the evidence of notifical nursing staff. A submote by RN-A dated included: "Did require (hour of sleep) for leffective." Further review of Finclude evidence of progress note dated The progress note dated The progress note dated The progress note included: (dark) pugspect of L (left) up aspect of L (left) up	ession data set (MDS) included mental status (BIMS) score of rate cognitive impairment. dicated R38 required total asfers and bathing, and se with bed mobility, nit, dressing, toilet use, and The care plan included a focus grity non pressure initiated as included: Conduct weekly onitor for signs and symptoms swelling, redness, warm, tify physician of significant assment to be completed per				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
0.0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	CENT, MN 5		ONI	0/5)
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE
22000	Continued From page 68		22000			
		c area of res.'s (resident's) be new and were not present				
		ssment paper form 7/19/16.				
		ation in a Gen. (general) Note				
		t) 2325 re: a L upper arm er to elbow, no measurement.				
	Background: Last f	all here at this facility is on				
	7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction)					
	prevention, has not be on p.o. or injectable					
		rapy her at GLC (Golden e admission. Most recent				
		s [sic] for post hip fx (fracture)				
		n). Medical hx (history) list				
		atelet or blood clotting factors o have increased mental				
	confusion on 8/16/1	16. Elderly male 96 y.o. (years				
		measurements - posterior L centimeters) L (long) x (by) 12				
		purple and soft. Lateral L				
		0 cm W is a lighter purple,				
		irm areas on either location. e to find a lab report in paper				
	chart re: a CBC (co	mplete blood count) or platelet				
		onse: This writer initiated a				
		staff for on-going assessment				
	and charting. This	writer will fax a note re: this				
		ian name] at local clinic. This that bruising is new				
		the notation in the 8/10/16				
	General Note/Progress Notes in PCC (point click care).					
		cation of Investigation report				
		pleted by the executive				
	director (ED) included Description of even	t/allegation: Bruising has				
	occurred from an u	nknown cause. NH (nursing de bruising to left arm and left				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00936	B. WING	·····	08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LA	CRESCENT	H HILL STR			
	T	LA CRESC	CENT, MN 5			
(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 APPROPERTION OF T	ULD BE COMPLETE	
	use for transfers. A nursing indicates by SBAR was completed notification completed Assessment of Resonated resident presupper arm from shown was unknown. SBANOC (night) nursed bruising as well as torso region. Bruismore swollen than open skin found on facility was 7/29/16 Resident interview pan to bruised area cause of bruising a	sident: on 8/10 it was first ented with new bruising to left bulder down to elbow, cause AR report was completed by 8/17 in relation to left arm extended bruising to left outer es are dark purple. Left arm is the right. No hematoma or assessment. Last fall in summary: Resident denies is. Resident is unable to recall and was unaware of bruising				
	cause of bruising and was unaware of bruising until notified by staff. Casual/contributing factors and observations: Resident had a fall on 7/29 from bed to floor. He is chronically on ASA 325 mg as only anticoagulation for MI prevention. Resident is dependent with all transfers which requires mechanical lift use and 1-2 person assist. Resident noted to have increased mental confusion since admission which is being monitored and documented by nursing. Resident has very fragile skin. Recommendation/interventions taken to prevent reoccurrence: More careful handling reinforced to CNAs during ADLs and mechanical lift transfers r/t (related to) fragile skin and anticoagulation medicine. Summary and outcome of investigative findings: Nursing, resident and family unable to determine exact time, location or occurrence in which bruising took place. There were no witnesses to an event. Only known event was from					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - LA	CRESCENT	TH HILL STR CENT, MN 5			
(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
22000	Continued From page 70		22000			
	Resident was evaluated and a skin examination took place on 8/17 by Dr [physician name]. No medication changes or further f/u (follow up) ordered by MD.					
	When interviewed of stated when a new identified the charge resident and initiate background, assess. The nurse would the a temporary care pleading in condition RN-A stated a bruis suspicious, would be further stated if bruis or if a larger bruise origin was identified also be reported to the 8/10/16 progres pertaining to R38's confirmed the resid left upper arm that of the elbow. RN-A stated bruising but verifications.	on 8/24/16, at 4:16 p.m. RN-A skin condition for a resident is enurse would assess the an SBAR (situation, sment, recommendation) note. en notify the physician, create an, and pass on the resident's in report to the next shift. He of unknown origin, if he reported to the State. RN-A sing was occurring frequently or hematoma of unknown and not explainable would the State. Surveyor reviewed as note written by RN-A left arm bruising. RN-A ent had large bruising to the extended from the shoulder to ated the resident had a history feel that this amount of bruising to resident. RN-A stated she				
	should have comple notified the physicia been done. RN-A f not been passed or	eted an SBAR note and an and confirmed that had not urther verified the bruising had a to the next shift, investigated nor reported to the State				
	director of nursing (issue is identified the source of the skin is complete an SBAR to the temporary pro	on 8/26/16, at 8:46 a.m. the DON) stated when a new skin the nurse should investigate the ssue, notify the physician, note, and add the skin issue oblem list to pass on to the assistants (NA's) are also to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00936	B. WING		08/2	6/2016	
				DRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - LA CRESCENT 101 SOUTH HILL STREET LA CRESCENT, MN 55947							
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE		
22000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		22000				

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