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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKJ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00213

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245084**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA**
(L4) **15409 WAYZATA BOULEVARD**
(L5) **WAYZATA, MN** (L6) **55391**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **11/01/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **84** (L18)
13.Total Certified Beds **84** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving (insert K tag) is recommended.

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 11/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/16/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 11/30/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 29, 2016

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Hillcrest Of Wayzata
15409 Wayzata Boulevard
Wayzata, MN 55391

RE: Project Number S5084026

Dear Mr. Onstad:

On September 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on September 8, 2016 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 8, 2016, effective October 24, 2016 and therefore remedies outlined in our letter to you dated September 27, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K067 at the time of the September 8, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245084 Y1	A. Building B. Wing Y2	11/1/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix F0315	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.25(d)	Completed
LSC	10/24/2016	LSC	10/24/2016	LSC	10/24/2016
ID Prefix F0329	Correction	ID Prefix F0425	Correction	ID Prefix F0431	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	10/24/2016	LSC	10/24/2016	LSC	10/24/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/24/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	PK/KJ	11/29/2016	33925	11/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/8/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245084	A. Building 01 - MAIN BUILDING 01 B. Wing	11/4/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 10/24/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 11/29/2016	SIGNATURE OF SURVEYOR 37009	DATE 11/4/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKJ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00213

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(L1) **245084**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA**
(L4) **15409 WAYZATA BOULEVARD**
(L5) **WAYZATA, MN** (L6) **55391**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **09/08/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **84** (L18)
13.Total Certified Beds **84** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 11/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/14/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/16/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
AW K67 sent to CMS - Rochi 11/14/2016 Co.
Posted 11/14/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 27, 2016

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Hillcrest Of Wayzata
15409 Wayzata Boulevard
Wayzata, MN 55391

RE: Project Number S5084026

Dear Mr. Onstad:

On September 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5084073 that was found to be unsubstantiated.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

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 24, 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 24, 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 8, 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 March 8, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING _____ B. WING _____	R 11/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	**15409 WAYZATA BOULEVARD WAYZATA, MN 55391**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based on review of the facility's plan of correction (POC), the facility is back in compliance with the Federal requirements identified as deficient at the time of their recertification survey exited 9/8/16. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the ePOC will be used as verification of receipt.	{F 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	**15409 WAYZATA BOULEVARD** **WAYZATA, MN 55391**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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, Fire Marshal Division on September 14, 2016. At the time of this survey, Golden Livingcenter Hillcrest of Wayzata 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 Street, Suite 145 St. Paul, MN 55101-5145, or By E-Mail to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2016

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter Hillcrest Wayzata is a 2-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1958, is 1-story, without a basement and was determined to be Type II (222) construction. In 1960 a two-story addition was constructed to the southwest of the original building down the hill and determined to be of Type II (111) construction. Another addition was constructed in 1973 to the east of the 1960 addition and determined to be Type II (222). In 1992 an in-fill addition was constructed to the east of the existing building, connecting an 2-story assisted living center which is a conforming construction and was determined to be of Type II (111) construction. The building is divided into 8 smoke zones by 1/2 hour fire barriers. The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a	K 000		

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K 000	Continued From page 2 capacity of 84 beds and had a census of 64 at the time of the survey. Because the original building and the additions are of the conforming construction types the facility was surveyed as 1 building Type II (111). The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 268 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on September 14, 2016, observation revealed that the ventilation system for the 1958 building appears to be utilizing the egress corridor as the supply air plenum for the resident rooms. There is no ducted return system with the only return appearing to be through the resident room bathroom fans. The HVAC system shuts down on fire alarm but the resident room bathroom fans continuously exhaust. This condition only affects the upper sub acute floor.	K 067	K067 Waiver Requested. Refer to justification on form Part IV Recommendations for waiver of Specific Life Safety Code Provisions; Form CMS-2786R.	10/24/16

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K 067	Continued From page 3 This deficient practice was verified by the Administrator at the time of the inspection.	K 067		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 69 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on September 14, 2016, observation revealed that the facility does not have a remote annunciator for the emergency generator. These deficient practices were verified by the Administrator at the time of the inspection.	K 144	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal requirements. F0144 The facility has received and approved an proposal for a contractor to install a remote annunciator for the emergency generator at the nurses station which is staffed 24/7. The project will be completed by 10/24/16. The facility management and nursing staff will be educated on the location and function of the annunciator once completed. The Administrator and/or designee will be responsible for compliance.	10/24/16

Name of Facility **2000 CODE**

Golden Living Center - Hillcrest of Wayzata

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 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with Life Safety Code (00) Section 9.2 and NFPA90A, 1999 Ed., because the corridors are being used as a plenum	A. An annual/continuing waiver is being requested for K-067. Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: 1. The most recent cost estimate, dated 10/23/2015, for a complying HVAC is $325,000. Financing this cost could add an additional $65,000 to $130,000. This cost does not take into account in needed project costs underway or planned at the facility. 2. A complying HVAC system has a large scope of work included at this facility. A project with a scope of this scale will force the high degree of disruption to the facility residents and the staff that care for the residents. The estimate includes a large degree of construction that has the possibility to displace over 40 residents at our facility as the potential to disrupt the entire upper sub acute floor. 3. The building is currently 58 - 24 years old and there are no known plans for the facility to be replaced and no end date has been determined for the buildings usable life. B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because: 1. The facility is Type II (222) and Type II (111) construction divided into 8 smoke zones by 1/2 hour fire barriers. 2. The building is fully fire sprinkler protected and the following life safety features are installed: Fire alarm monitoring system with addressable smoke detectors, Fire Dept. notification and Fire Extinguishers. 3. In accordance with LSC 18.7.2.2/19.7.2.2, the facility has a compliant fire safety plan. 4. The facility addresses the following operational plans: Housekeeping, Smoking, and Fire Watch. 5. There is a total of 8 smoke zones in the facility. 6. No residents reside on the lower level of the SNF. 7. The closest fire department is 2 miles away and has an average response time of less than 6 minutes.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 10/07/2016

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
September 27, 2016

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Hillcrest of Wayzata
15409 Wayzata Boulevard
Wayzata, MN 55391

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5084026 & H5084073
Dear Mr. Onstad:

The above facility was surveyed on September 6, 2016 through September 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5084073 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Pam Kerssen RN, APM at (218)308-2129.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00213	A. BUILDING: _____ B. WING _____	C 09/08/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 6, 7 and 8, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which 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.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. During the survey, an investigation of complaint H5084073 was completed. The complaint was unsubstantiated.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacture's directions when administering insulin by a pen for 1 of 1 residents (R72) observed to receive a lispro and glargine insulin by an insulin pen. Findings include: R72's admission Minimum Data Set (MDS), dated 8/3/16, identified R72 was diagnosed with diabetes mellitus (metabolic disease causing increased blood glucose levels and may require	2 830		

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2 830	Continued From page 3 insulin) and required daily insulin injections to manage his blood sugars. Review of R72's signed physician order report, dated 9/7/16, identified R72 received prescribed sliding scale lispro (shorting acting insulin) three times a day before meals and glargine (long acting insulin) twice a day. During observation on 9/8/16, at 12:41 p.m. licensed practical nurse (LPN)-B stated R72's blood sugar was over 200 and she was going to need to administer 4 units of lispro and 10 units of glargine before lunch. LPN-B gathered her gathered her supplies (insulin pens, needles, alcohol wipes, gloves) and placed them on her medication cart. LPN-B wiped the hub of the insulin pen and affixed the needle to the tip of the insulin pen. LPN-B drew up 4 units of Lispro with the first insulin pen and showed this to the surveyor. LPN-B then wiped the hub of other insulin pen with alcohol and affixed the needle to the insulin pen. LPN-B drew up 10 units of glargine and showed this to the surveyor. LPN-B proceeded to knock on R72's door and explain to him (R72) she was going to administer his insulin. LPN-B donned gloves and wiped two separate areas with alcohol on R72 abdomen. LPN-B proceeded to inject R72's glargine and then his lispro into his abdomen. During interview on 9/7/16, at 12:17 p.m. LPN-B stated she had "forgotten" to prime both the lispro and glargine insulin pens prior to administration of R72's insulin. Further, LPN-B stated the purpose of priming the insulin was to prevent air from being in the insulin syringe and to ensure R72 was receiving the correct dose of insulin. When interviewed on 9/8/16, at 12:41 p.m. LPN-A	2 830		

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2 830	Continued From page 4 stated the purpose of priming the insulin pen prior to administration of insulin was to prevent air from being in the injection and to ensure R72 was receiving the correct dose of insulin. LPB-A further stated all employees had recently received education on the proper use of insulin and it was her expectation employees follow current standards of practice. During interview on 9/8/16, at 12:49 p.m. director of nursing (DON) stated she was unsure of the correct way to administer insulin and staff should follow the facility's standards of practice when giving insulin. Further, DON stated all licensed staff recently received mandatory education on how to correctly administer insulin. The package leaflet for lispro insulin: Information for the User dated 1/16, directed to prime the insulin pen before each use to ensure insulin comes out and clears air bubbles from the insulin pen. The package leaflet for Lantus Solostar (glargine): How to Use Your Lantus Solostar Pen (undated) directed to dial a test dose of 2 units of insulin to ensure insulin comes out of the needle. Based on observation, interview and document review, the facility failed to ensure expired insulin (medication used to treat diabetes) was removed from medication carts and was not administered to 1 of 1 residents (R33) reviewed for medication storage. Findings include: On 8/3/16, at 11:25 a.m. registered nurse (RN)-B was observed to have an expired Humalog Kwik insulin with an expiration date of 8/31/16. During interview on 8/3/16, at 11:25 a.m. RN-B	2 830		

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2 830	Continued From page 5 verified the insulin was expired and stated R33 had been administered three doses of expired insulin on 9/1/16, 9/2/16, and 9/3/16. Further, RN-B stated there were no other insulin pens for R33 located on the medication cart. When interviewed on 9/8/16, at 12:41 p.m., LPN-A stated night staff were responsible for checking medication carts once a week for expired medications. Further, LPN-A stated Humalog Kwik insulin pens are only good for 28 days after they are opened because there is the potential the insulin "could loose its effectiveness," if used after its expiration date. During interview on 9/8/16, at 12:49 p.m., director of nursing (DON) stated medication carts were to be checked by licensed night staff at least once a week for expired medications. Further, DON stated Humalog Kwik pens expired 28 days after they were opened and would not "be as effective" if used after the expiration date. The package insert: Information for the User on Humalog Kwik insulin pen (revised 1/16), directed the insulin pen should be discarded after 28 days. The facility policy Diabetes Management (undated) directed once multidose vials of insulin are opened for administration they are considered stable for up to 28 days. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) of designee could inservice nursing staff concerning timely disposal of expired medication from the supply; and ensure correct dosing is administered with use of insulin injection pens. The DON could then audit to ensure compliance.	2 830		

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2 830	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and provide medical justification for the continued use of an indwelling catheter for 1 of 3 residents (R57) reviewed for urinary catheter use. Findings include: R57's quarterly Minimum Data Set (MDS) dated 7/27/16, identified R57 had severe cognitive impairment, used an indwelling catheter, and a trial voiding program had never been attempted	2 910		

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2 910	Continued From page 7 for R57. During interview on 9/7/16, at 12:15 p.m. licensed practical nurse (LPN)-A stated R57 had an indwelling Foley catheter (device used to manage urine from the bladder) which had been placed during a hospitalization earlier in the year. LPN-A stated the medical diagnosis for R57's catheter was, "Enlarged prostate with lower UTI [urinary tract infection] symptoms." R57's hospital dismissal summary dated 1/27/16, identified R57 had a Foley catheter in place, and listed a primary diagnosis for the device of "Urinary incontinence." R57's current signed physician orders dated 8/25/16, identified R57 had a Foley catheter in place for, "Urinary retention &obstructive [sic] uropathy d/t [due to] BPH [benign prostate hypertrophy]." R57's External Facility Episodic Visit report dated 6/24/16, identified R57 had been seen by the nurse practitioner whom documented R57 had, "Urinary retention - Foley was removed 6/21 or 6/22, nursing unsure why. Did void at times. Foley reinserted with difficulty on 6/23. [R57] Has had some episodes of increased confusion since. Nursing asking for UA [urinalysis, test used to determine if an infection is present in the bladder]." R57's medical record was reviewed. There was no identified reassessment of R57's urinary elimination or indwelling catheter use when he had been identified to be voiding without a catheter by the practitioner. When interviewed on 9/7/16, at 5:58 p.m. nursing	2 910		

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2 910	Continued From page 8 assistant (NA)-B stated R57 had a catheter in place because staff, "Want to make sure he's urinating enough." NA-B stated she was not aware if R57 had a history of developing UTIs because, "They [nurses] don't tell the aides things like that." During interview on 9/7/16, at 7:00 p.m. LPN-A stated R57 admitted to the nursing home with a Foley catheter in place. The facility had determined it was medically necessary for R57 from reading, "Information we received from the hospital." LPN-A stated R57 had pulled out his catheter on 6/21/16, and staff reinserted it on 6/23/16, with no assessment being completed of R57's voiding to determine if the catheter was still medically necessary. LPN-A stated R57's catheter was reinserted on 6/23/16, only because the practitioner was updated and, "Wrote order to reinsert." During interview on 9/8/16, at 1:21 p.m. the director of nursing (DON) stated R57 should have been trialed with voiding prior to having the catheter reinserted, "We should of reassessed." A facility policy on urinary catheter use was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding medical justification for use of an indwelling Foley catheter, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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21426	Continued From page 9	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a required symptom screening and required two step tuberculin skin test (TST, a Mantoux test) were completed for 3 of 5 residents (R28, R57, R182) reviewed for tuberculosis (TB) prevention and management. Findings include: R28's medical record lacked a baseline TB screening. R28's 1st step TST was administered on 8/18/16, at 9:00 p.m. with results read on	21426		

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21426	Continued From page 10 8/19/16, at 9:10 p.m. 24 hours and ten minutes after administration of test. The 2nd step TST was administered on 8/27/16, at 10:00 p.m. and results were read on 8/29/16, at 10:00 a.m., 36 hours following administration of TST. R57's medical record lacked a baseine TB screening. R57's 1st step TST was administered on 1/27/16, but was not read. The 2nd step TST was documented as administered on 2/5/16, however, lacked the time of administration. The results were noted as read on 2/8/16, with no time indicated, with 0 millimeters (mm) of induration, with interpolation marked as a negative result. R182's 1st step TST administered on 9/2/16, at 9:00 p.m., with results read on 9/4/16, at 1:00 p.m. with 0 mm of induration, indicating a negative result. The results were read 40 hours after administration of the TST. During interview 9/7/16, at 6:32 p.m. licensed practical nurse (LPN) verified the TSTs were read outside the recommended time frame, which she stated should be completed "between 48-72 hours after administration of the TST." LPN-A also verified residents should be screened for active TB prior to the administration of the 1st Step TST. When interviewed on 9/8/16, at 1:16 p.m. the assistant director of nursing (ADON), stated Mantoux results are to be read 48-72 hours after administration. The facility policy Tuberculosis Infection Control Program dated 12/01/2014, under the TB Exposure Control Plan, Guidelines for skin testing for new admissions and new hires directed screening and surveillance of residents. the policy	21426		

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21426	Continued From page 11 further dierected "All new admissions ...will receive a 2 step Mantoux PPD (purified protein derivative-solution used to complete TST). Step I is to be received upon admission. Step II is to be administered 7-10 days after Step I, if Step I is negative. Read the PPD results within 48-72 hours of administration. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure TB screening and TSTs are completed according to the Centers for Disease Control. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		

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21535	Continued From page 12 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate medical justification for use of antipsychotic medication for 1 of 5 residents (R28) reviewed for unnecessary medication use. Findings include: R28 admission Minimum Data Set (MDS) dated 8/24/16, identified R28 had dementia with severe cognitive impairment, and displayed no physical or verbal behaviors. The MDS also indicated R28 had delusions, but displayed no hallucinations or delirium. During observation on 9/6/16, at 3:43 p.m. R28 was seated in her wheelchair in the commons area with several other residents. R28 was participating in an activity with bird houses and displayed no behavioral symptoms while conversing with the other residents. During subsequent observation on 9/7/16, at 11:56 a.m. R28 was seated in the commons area with several other residents participating in a musical sing-a-long activity. R28 had no distressed facial expressions, and displayed no behavioral symptoms.	21535		

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21535	Continued From page 13 R28's signed admission orders dated 8/17/16, identified an order for, " QUEtiapine Fumarate [Seroquel, an antipsychotic medication] ... Give 12.5 mg [milligrams] by mouth as needed for agitation May take 12.5 mg bid [twice a day] prn [as needed]." R28's Consulting Pharmacy Review dated 8/17/16, identified a concern from the pharmacist of, "Seroquel prn dosing: inappropriate," and directed, "Recommendations made." R28's subsequent physician order dated 8/22/16, identified a request from the facility nursing staff to discontinue the as needed order for R28's Seroquel and start, "Seroquel 12.5 mg PO [by mouth] Q HS [every bedtime]." Further, the order identified a diagnosis for the Seroquel of, "Atypical psychosis [and] paranoia/hallucinations." R28's progress notes dated 8/17/16, through 8/22/16, identified only one documented behavior for R28 in which staff identified her to be, "Very anxious this shift," and talking about, "Being lost," and seeking her family. R28's untitled behavior flowsheets dated 8/18/16 through 8/19/16, identified R28 displayed only two behaviors since her admission to the facility. R28 had, "Paranoid statements" recorded once, along with having a, "Frantic" episode. R28's Resident Behavior Log dated 8/17/16, through 9/9/16, identified R28 to have two documented episodes of, "Wandering." No other behaviors were documented. R28's Medication Administration Record (MAR) dated 8/2016, identified R28 had never received a dosing of the as needed Seroquel since her	21535		

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21535	Continued From page 14 admission to the facility. However, on 8/22/16, started to receive the scheduled Seroquel as ordered by the physician. R28's medical record lacked supporting documentation identified to address why R28 had been started on a scheduled antipsychotic medication when she had not ever required the "as needed" antipsychotic medication. During interview on 9/8/16, at 8:59 a.m. registered nurse (RN)-C reviewed R28's MAR and stated R28 had not ever been provided the "as needed" Seroquel since her admission to the facility. RN-C stated R28's Seroquel had been scheduled because she had taken it before during a previous stay at the facility. Further, RN-C stated the facility would look at potentially decreasing the medication during their next psychotropic drug meeting. A facility Antipsychotic Medication Review policy dated 3/7/16, identified a procedure which included, "The Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness an necessity for the use of the drug." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding medical justification and need for use of psychotropic medication, then audit resident samples to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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21665	Continued From page 15	21665		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide maintenance services and ongoing repairs, and a clean and sanitary environment in 6 of 8 resident rooms (RM)-274, RM-254, RM-251, RM-279, RM-286, RM-270B) reviewed for environmental concerns. Findings include: On 9/8/16, at 10:40 a.m. a tour of the facility with the maintenance director (MD)-A and the housekeeping manager (HM)-A and the following concerns were identified: In RM-274, several large gouges and scratches were observed on the painted wall along the head of the resident's bed, two areas measuring approximately 3/4 " (inches) x 16" exposing the plaster, and three areas measuring approximately 1/2" x 8". Another area directly behind the head of the resident's bed had three large gouged areas exposing the plaster and a rough uncleanable surface, measuring approximately 2" x 8" and 2" x 12". In RM-254, several gouges and scratches were observed on the wallpapered outer wall of the bathroom, exposing a rough and uncleanable surface of torn wallpaper and plaster, measuring approximately 2" x 24", 1/2" x 8", 1/2" x 6", 1/2" x	21665		

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21665	Continued From page 16 4' and 1/3" x 18". In addition, the floor was observed with debris, small pieces of paper, dust, tissues, and small blue plastic pieces, throughout the room including under the bed and behind chairs in the room. In RM-251, two strips of wallpaper, approximately 1" x 5" in size, were torn and hanging on the wall near the bathroom door. The metal door knob on the outside of the bathroom door had a large dent, which had an exposed sharp edge that was felt when turning the knob to enter the bathroom. Inside the bathroom, a plastic toilet riser was sitting on top of the right side of the vanity. The toilet riser was soiled with a brown substance, smeared across the lower back and the front portion of the seat. In RM-279, the metal heater had scuff marks and scrapes in the paint across the entire front surface, exposing a rough uncleanable surface. In RM-286, the floor was damp and a wet floor caution sign was observed in the doorway of the room. HM indicated the housekeeping staff had just finished cleaning the room, however, the bathroom sink and vanity had dark colored dried spots, black debris, and several brown hairs. In RM-270B, the foot board of the resident's bed was observed to be hanging off the frame of the bed, with one side resting on the floor. During an interview on 9/8/16, at 11:05 a.m. MD-A indicated wall protectors had been placed on some of the beds to prevent the beds from causing damage to the walls, and wallpaper repairs were "Ongoing." MD-A indicated they were running out of wallpaper to use for the repairs, so in some rooms, they had to remove	21665		

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21665	Continued From page 17 the wallpaper and repair the wall, and then needed to paint the room. MD-A indicated staff were to report repairs that were needed, on the computer in the hallway, and he received that information via email. MD-A indicated he had not been notified about the dented doorknob or the footboard that had fallen off. MD-A stated residents' rooms were checked quarterly by the maintenance staff, and any needed repairs that had not been reported, were completed at that time. During an interview on 9/8/16, at 11:10 a.m. HM-A indicated resident rooms were to be cleaned daily, which included sweeping and washing the floors, and cleaning the bathrooms. HM-A stated the soiled sink, vanity, toilet riser, and floor, were "Not acceptable," and the housekeeping staff would be re-educated. The facility policy General Maintenance Inspections (undated) directed "It is the policy of this facility to hold routine maintenance inspections as a part of a general facility safety inspection." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures for ensuring timely repairs of the physical plant, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		

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21805	Continued From page 18 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R157, R32) observed for dignity were spoken to in a dignified manner. Findings include: R157's admission minimum data set (MDS), dated 7/15/16, identified R157 had no cognitive impairment. During observation on 9/7/16, at 4:41 p.m. nursing assistance (NA)-C was helping assist R157 with personal care in the bathroom. NA-C instructed R157 to stand and grab onto the grab bar during which NA-C stated, "I am going to change your diaper now." After NA-C placed a new incontinent product on R157, he proceeded to tell R157 he was going to throw away his old "diaper" in the trash. When interviewed later on 9/7/16, at 6:13 p.m. R157 stated the term "diaper" made him "feel like a baby." When interviewed on 9/7/16, at 6:17 p.m. NA-C stated he called the incontinent product a "diaper" because that's "what it was" and he wanted R157 to be aware of the situation during his personal cares. NA-C further stated it was not un-dignified and saw "no issue" with calling the incontinent product a "diaper."	21805		

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21805	Continued From page 19 During observation on 9/8/16, at 8:52 a.m. registered nurse (RN)-C was helping to assist R157 out in the dining room with his medications. After RN-C administered R157's medications, she stated "do you want your bib now" and R157 agreed to have it placed on him. A couple of minutes later, RN-C again approached R157 out in the dining room and asked, "where is your bib?" During interview on 9/8/16, at 9:42 a.m. RN-C stated she had called the clothing protector a "bib" because she had heard R157 use the term in the past. RN-C further stated the term "bib" could be considered undignified because it is often referred to in reference to infants. During interview on 9/8/16, at 12:41 p.m. licensed practical nurse (LPN)-A stated it was undignified to use the term "bib" and "diaper" as these terms often referred to young children and not adults When interviewed on 9/8/16, at 12:49 p.m. director of nursing (DON) stated it was "un-dignified" to use terms such as "bib" or "diaper" as the residents were considered adults and not "young children." DON further stated facility staff using these terms would need further education on the matter. R32's quarterly MDS, dated 8/18/16, identified R32 as having a severe cognitive deficit, with an active diagnosis of dementia, and needing extensive assistance with personal hygiene and dressing. R32's care plan (CP), last reviewed 11/16, contained the goal to "have my [R32] dignity maintained through my next review." In addition, the CP directed staff to "Help me [R32] maintain	21805		

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my dignity" along with giving R32 reminders, cues, and assistance to make safe choices. It did not specify ways in which staff could assist R32 in maintaining her dignity.

During observation on 9/7/16, at 6:17 p.m. NA-A and trained medication assistant (TMA)-A assisted R32 to transfer from her wheelchair to the bed using a standing lift. While R32 was standing with the assistance of the lift, NA-A and TMA-A pulled down R32's pants and took off her incontinent brief, during which, TMA-A stated "we are going to change your diaper." NA-A and TMA-A continued to complete hygiene cares while R32 was standing in the lift, and, although R32 made no reaction to the use of the term "diaper," she tried to pull up her pants and appeared to want to cover herself before the cares were completed and a new incontinent brief was applied.

When interviewed on 9/7/16, at 7:51 p.m. TMA-A denied using the term "diaper" to describe R32's brief stating he "didn't remember saying that." He further stated R32 was less resistive to cares while standing than when she was in the bed, reporting that once in bed she just wanted to be covered up.

On 9/8/16, at 8:34 a.m. DON stated the facility did not have a policy on dignity; however, staff were to go by the resident bill of rights when providing care.

When interviewed later on 9/8/16, at 12:20 p.m., RN-A stated the term "diaper" was "undignified" and staff should try to call it a brief and provide privacy during cares. She further stated the nursing assistants were educated on appropriate word choices during orientation.

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21805	Continued From page 21 A facility policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) of designee could inservice staff regarding not speaking to resident using demeaning terms and then audit cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason	21830		

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to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident

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21830	Continued From page 23 and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to offer and/or accommodate resident choices regarding bathing preferences for 1 of 3 residents (R33) reviewed for choices. Findings include: R33's admission Minimum Data Set (MDS) dated 6/22/16, indicated R33 was cognitively intact and was totally dependent for bathing. The MDS also indicated it was very important for R33 to have the choice between a tub bath, shower, bed bath or sponge bath.	21830		

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21830	Continued From page 24 During interview on 9/6/16, at 3:43 p.m. R33 stated she preferred a tub bath but was always given a shower. R33 further stated staff did not offer her a choice between a shower and a tub bath, and added, "I think showers are more convenient for them [staff]." An undated CNA (certified nursing assistant) Team 2 Care Assignment task sheet indicated R33 received bathing assistance on Sunday afternoons and Thursday mornings, and listed all residents on the unit as receiving a shower. R33 was observed on 9/8/16, at 7:35 a.m. while nursing assistant (NA)-D wheeled R33 via shower chair to the bathing room. The room was observed to have only a shower available. NA-D walked over to the shower, started the water, and got R33 ready for a shower. NA-D did not offer R33 a choice regarding whether she would prefer a tub bath or shower. NA-D proceeded to give R33 a shower. During interview on 9/8/16, at 9:38 a.m., NA-D stated that he never offered R33 a choice between a tub bath and a shower because, "We have showers here." NA-D indicated the only bath tub available was in the assisted living area and stated, "If the resident insists that they want a bath, we take them down there." NA-D verified the CNA task sheet listed all residents on Team 2 received a shower, and stated, "We just have a shower here. We don't really offer them a choice. We don't ask about it unless the resident asks for it." During an interview on 9/8/16, at 12:12 p.m., NA-E stated, "Most of the time we give showers. Shower is listed on the care sheet. Everybody gets a shower."	21830		

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21830	Continued From page 25 During an interview on 9/8/16, at 12:39 p.m. the director of nursing (DON) indicated residents are informed upon admission of the shower schedule and are told to let the staff know if they want something different. DON stated, "We don't specifically ask them if they want a tub bath." DON stated if a resident indicated it was very important to have the choice between a tub bath, shower, bed bath or sponge bath, "Common sense tells me that person that asks that question would follow up on that." A policy for accommodating resident preferences regarding bathing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) of designee could review and revise polices concerning bathing preferences in the facility, educate staff, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		