DEPARTMENT OF HEALTH	AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
	MEDIC	CARE/MEDICA	ID CERTIFIC	CATION	AND TRANSMITTAL	ID: EKK7
	PART I	- TO BE COMP	PLETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00872
1. MEDICARE/MEDICAID PROVIDER 1 (L1) 245293 2.STATE VENDOR OR MEDICAID NO. (L2) 417633200	NO.	 NAME AND AI (L3) GOLDEN L (L4) 725 SECON (L5) HOPKINS, I 	IVINGCENTE D AVENUE SO	R - HOPK	INS (L6) 55343	 TYPE OF ACTION: <u>9</u>(L8) Initial Recertification Termination CHOW Validation Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 11/01/2002	NERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 12/10/2013 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED A	S:		
From (a): To (b): 12.Total Facility Beds	138 (L18)	Compliar	nce With Requirements nce Based On: Acceptable POC		And/Or Approved Waivers Of Tl2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF	 6. Scope of Services Limit 7. Medical Director 7. <u>X</u> 8. Patient Room Size
13.Total Certified Beds	138 (L17)		mpliance with Prog ents and/or Applied		5. Life Safety Code * Code: A,8	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	E):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
				(L19)	Mark Meath, Progr	cam Specialist, 03/20/2014
PA	RT II - TO BI	COMPLETED	BV HCFA P		L OFFICE OR SINGLE ST	(L20)
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Par	,	20. COM	MPLIANCE WITH		21. 1. Statement of Finar	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 10/01/1985	BEGINNING	DATE	ENDING DAT	ſΈ	VOLUNTARY 00 01-Merger, Closure 0	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	(L44)		0+-Oulei Reason for Windrawar	07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	spension Date:	(211)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	00040		(L31)		
					-	
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL D	ATE		
	(L32)	12/23/2013		(L33)	DETERMINATION APPR	ROVAL

DEPARTMENT OF HEALTH AND	HUMAN SERVICES	CENTERS FOR MEDICARI	E & MEDICAID SERVICES
	MEDICARE/MEDICAID CERTIFICATION A	ND TRANSMITTAL	ID: EKK7
	PART I - TO BE COMPLETED BY THE STAT	E SURVEY AGENCY	Facility ID: 00872
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS		
CCN: 24-5293	REVISED		

The CMS 1539 is revised to add deficiency F458 approved for a room size waiver.

Post Certification Revisit completed on December 10, 2013, by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal certification regulations.

Documentation supporting the facility's request for a continuing waiver involving the deficiency cited at F458 for resident room size requirements was forwarded to the Region V Office of CMS with our recommendation for approval.

Please refer to the CMS 2567B. Effective December 4, 2013, the facility is certified for 138 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

REVISED

CMS Certification Number (CCN): 24-5293

March 20, 2014

Ms. Kimberly Lyon, Administrator Golden LivingCenter - Hopkins 725 Second Avenue South Hopkins, Minnesota 55343

Dear Ms. Lyon:

This certification letter is revised to include your request for waiver of F458. In addition, a revised cms 2567b for is enclosed with the F458 removed as it is not corrected, but waived.

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 December 4, 2013 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 138 skilled nursing facility beds.

Your request for waiver of F458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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

Golden LivingCenter - Hopkins March 20, 2014 Page 2

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

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

December 20, 2013

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Hopkins 725 Second Avenue South Hopkins, MN 55343

RE: Project Number S5293023

Dear Ms. Lyon:

On November 15, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 25, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E).

On December 10, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 9, 2013 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 October 25, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 4, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 25, 2013, effective December 4, 2013 and therefore remedies outlined in our letter to you dated November 15, 2013, will not be imposed. Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. 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,

Gloria Derfus

Gloria Derfus, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

Golden Livingcenter - Hopkins

Page 2

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CL Identification Number 245293	IA / ()	Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/10/2013
Name of Facility			Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTE	ER - HOPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	

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).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii),	, (c)(2		ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 12/04/2013		ID Prefix Reg. # LSC	F0242 483.15(b)		Correction Completed 12/04/2013
ID Prefix Reg. # LSC			Correction Completed 12/04/2013	ID Prefix			Correction Completed 12/04/2013		ID Prefix	F0309 483.25		Correction Completed 12/04/2013
ID Prefix Reg. # LSC	F0311 483.25(a)(2)		Correction Completed 12/04/2013	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 12/04/2013		ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 12/04/2013
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC								
Reviewed I	3v Revie	ewed	By	Date:	Signature	of Sur	vevor:				Date:	
State Agen			/MM	3/20/20	-		8626					12/10/2013
	3y Revie			Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Complete 10/25/201		:		Check for any Uncorrecte					Summary of the Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245293	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 12/9/2013
Name of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - HOPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	

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).

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Ite	em	(Y5)	Date
ID Prefix	<	C	Correction Completed 2/04/2013	ID Prefix		Correction Completed	ID	Prefix		Correction Completed
	# NFPA 101			Reg. #			i	Reg. #		
LSC	K0046			LSC				LSC		
		C	Correction			Correction				Correction
ID Profi	,	C	Completed	ID Profix		Completed		Profix		Completed
	×									
Reg. # LSC	* 			Reg. # LSC						
		C	Correction			Correction				Correction
ID Prefiz	K		Completed	ID Prefix		Completed	ID	Prefix		Completed
Reg. #										
	# 			LSC						
		C	Correction			Correction				Correction
ID Prefix	к	(Completed	ID Prefix		Completed	ID	Prefix		Completed
Reg. #										
	#									
ID Prefiz	<	C	Correction Completed	ID Prefix		Correction Completed	ID	Prefix		Correction Completed
Reg. #	ŧ			Reg. #				-		
LSC				LSC				LSC		
Reviewed		Reviewed I	Ву	Date:	Signature of Sur				Date	-
State Age	ncy	PS/cbl		01/16/2014	186	526			12/	09/2013
Reviewed CMS RO	Ву	Reviewed I	Зу	Date:	Signature of Sur	veyor:			Date	:
Followup	to Survey Con 10/28	pleted on: 2013			Check for any Uncor Uncorrected Defic					o NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245293	(Y2) Multiple Con A. Building B. Wing	8 ADDITION	(Y3) Date of Revisit 12/9/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - HOPKINS			725 SECOND AVENUE SOUTH HOPKINS, MN 55343	

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).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 12/04/2013	ID Prefix		Correction Completed	ID Prefix		Correction Completed
-	NFPA 101 K0046		Reg. #			Reg. # LSC		
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correction Completed			
Reg. #					Correction Completed	Reg. #		
Reg. #					Correction Completed			
Dec #			Dec. #			D.a. #		
Reviewed B State Agen Reviewed B CMS RO	PS/cbl	-	Date: 01/16/2014 Date:	Signature of Sur 192 Signature of Sur	51		Date: 12/ Date:	09/2013
	o Survey Completed on 10/28/2013	1:	(Check for any Uncor Uncorrected Defic				NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL 'E SURVEY AGENCY	ID: EKK7 Facility ID: 00872
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245293 2.STATE VENDOR OR MEDICAID NO. (L2) 417633200).	3. NAME AND ADI (L3) GOLDEN LI (L4) 725 SECOND (L5) HOPKINS, M	VINGCENTER - 1 AVENUE SOUT	HOPKIN	S (L6) 55343	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
 5. EFFECTIVE DATE CHANGE OF OWN (L9) 11/01/2002 	ERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY 10/25/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF) 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 138 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	138 (L18) 138 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Comp Requireme ICF (L42)	ce With quirements Based On: cceptable POC bliance with Program nts and/or Applied W IID (L43)	'aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B,8 * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
See Attached Remarks 17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Rebecca Wong, HFE		1	11/29/2013	(L19)	Mark Meath, Enfor	rcement Specialist 3/24/2014
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Parti 2. Facility is not Eligible		20. COM	D BY HCFA RE		21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above :	
22. ORIGINAL DATE OF PARTICIPATION 10/01/1985 (L24)	23. LTC AGREEMI BEGINNING I (L41)		4. LTC AGREEMEN ENDING DATE (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
	(L28)	00040		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C 12/23/2013	OF APPROVAL DAT	E		
	(L32)	-2,20,2010		(L33)	DETERMINATION APPRO	VAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EKK7

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY
 Facility ID: 00872

 C&T REMARKS - CMS 1539 FORM
 STATE AGENCY REMARKS

CCN: 24-5293

On October 25, 2013 a standard survey was completed at this facility. Deficiencies were found, the most serious at a Scope and Severity (S/S) Level of F. The facility has been given an opportunity to correct before remedies are imposed.

The facility is requesting a room size waiver involving the deficiency cited at F458. Documentation supporting the waiver request is attached and a copy will be forwarded to the CMS Region V Office. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction for the results of the survey.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 6898

November 15, 2013

Ms. Brooke Viegut, Administrator Golden LivingCenter - Hopkins 725 Second Avenue South Hopkins, Minnesota 55343

RE: Project Number S5293023

Dear Ms. Viegut:

On October 28, 2013, 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.

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>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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792 Fax: (651) 201-3790

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 December 4, 2013, 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 December 4, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

Golden LivingCenter - Hopkins November 15, 2013 Page 3

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is

Golden LivingCenter - Hopkins November 15, 2013 Page 4 acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 24, 2014 (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

Golden LivingCenter - Hopkins November 15, 2013 Page 5

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 April 24, 2014 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Golden LivingCenter - Hopkins November 15, 2013 Page 6

Feel free to contact me if you have questions.

Sincerely,

moton Katol >

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Annuall Room size waiver is being requested @ F458
--

		AND HUMAN SERVICES	·			1 APPROVED). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	TIPLE CONSTRUCTION	CO	TE SURVEY MPLETED
		245293	B. WING			/25/13 per /24/2013
AME OF F	PROVIDER OR SUPPLIER	I	1	STREET ADDRESS, CITY, STATE, ZIP		2112010
				725 SECOND AVENUE SOUTH		
OLDEN	LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
REFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETION DATE
				Submission of this R		
F 000	INITIAL COMMEN	ГS	F	00) and Plan of Correcti		
				not a legal admissio		
	The facility's plan of	of correction (POC) will serve		deficiency exists or		
		of compliance upon the		this Statement of De	_	
		ptance. Your signature at the		was correctly cited, also not to be const		AVV START RV
		age of the CMS-2567 form will		an admission of faul	1	
	be used as verificat	tion of compliance.		facility, the Execut		
- 10-	7			Director or any empl		
		acceptable POC an on-site		agents or other indi	viduals	E Style C
		y may be conducted to		who draft or may be		41 St (39)
		Initial compliance with the		discussed in this Re	-	
/ 1º		en attained in accordance with		and Plan of Correcti		Ľ.
F 005	your verification.	(a)(2) (A)		addition, preparatio		
F 225	483.13(c)(1)(ii)-(iii), INVESTIGATE/REI	(C)(2) - (4)	Г	225 submission of this E	lan of	12-4-13
SS=D	ALLEGATIONS/INI			Correction does not		
	ALLEGATIONS/INI	JIVIDOALS		constitute an admiss agreement of any kir		
< H	The facility must no	ot employ individuals who have		facility of the trut		
		f abusing, neglecting, or	9	facts alleged or the		
а.		ts by a court of law; or have	5	correctness of any	•	and they
		ed into the State nurse aide	MA	conclusions set fort	h in the	
	registry concerning	abuse, neglect, mistreatment appropriation of their property;	43	allegations.		
		wledge it has of actions by a	20	Accordingly, the Fac	vilitv	
		t an employee, which would	= +	has prepared and sub		
		or service as a nurse aide or	53	the Plan of Correct		
		the State nurse aide registry	127	to the resolution of		
	or licensing authori		BZ	appeal which may be	filed	
			501	solely because of the		
	The facility must er	nsure that all alleged violations	3~	requirements under s		
		nent, neglect, or abuse,	3	federal law that man		
		funknown source and	S	submission of a Plan	1	
	· · · ·	f resident property are reported		Correction within to		
		administrator of the facility and		days of the survey a condition to partic:		
		accordance with State law		the Title 18 and Ti		
		d procedures (including to the		programs. This Plan		
:	State survey and c	ertification agency).		Correction is submi-		
9	The facility must be	ave evidence that all allocad		the facility's cred		
\$ ¹	The facility must ha	ave evidence that all alleged		allegation of compl.		
		DER/SUPPLIER REPRESENTATIVE'S SIG	;	TITLE	Anterest and a second	(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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	2: 11/13/2013 APPROVED 2: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	re survey MPLETED /25/13 per
		245293	B. WING				124/2013
NAME OF F	PROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		24/2013
					25 SECOND AVENUE SOUTH		
GOLDEN	I LIVINGCENTER - HO	OPKINS			OPKINS, MN 55343		
		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ao 1	C '	225	H 005		
1 220		-	Γ 2	225	F 225		· .
		ughly investigated, and must			* All allegations of ab	120	
		ential abuse while the			for resident R222 will be		
11 12 1	investigation is in p	rogress.		1.000 A	reported immediately to		a na warata
	The regults of all in	vestigations must be reported			State Agency.		
	to the administrator			1	* All allegations of ab	use	
		to other officials in accordance			for all vulnerable adult		
		uding to the State survey and			residing in the facility		
) within 5 working days of the			be reported immediately		1
		alleged violation is verified			the State Agency.		1942
		ive action must be taken.			* All facility staff have	ve	1
	appropriate correct				been educated on the		1 T
					requirement of immediate		
					reporting of all alleged		and the second sec
	This REQUIREME	NT is not met as evidenced			resident abuse under the		
	by:				Vulnerable Adult Law. A	11	
		v and document review, the			facility staff have been		
		ort an allegation of abuse to			educated on the facility	's	میده می اید. ا
	the State agency (S	SA) immediately for 1 of 4			procedures to encompass		
	residents (R222) re	eviewed for alleged abuse.			immediate reporting of a	11	
	,	J.			alleged abuse.		
	Findings include:				* Monitoring to ensure		
2					compliance will be condu	cted	
		nt reporting logs from 12/6/12,			by the DNS through the	-	5 3
		revealed a complaint of sexual			vulnerable adult reporti		
	abuse.				and tracking logs mainta by the facility.	inea	
61					* The facility QAPI		
		oted on 9/29/13, at 8:00 p.m.			committee will review th	e	
		ory care) unit the "nursing			status of immediate	-	and the second sec
		rted to charge licensed			vulnerable adult reporti	ng	
		N] that R214 was observed			quarterly for further	_	
		an empty room alongside			recommendations.		
		s hand down the pants of			* The date of completion	n is	
		ts were told by the NA that it			12-4-13.		
		ave the room and both					
		d left. Both residents have					
		a, nonsensical conversation					
	sustained injuries."	rviewed, neither resident					
	sustained injunes.						i

If continuation sheet Page 2 of 57

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/13/2013 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	CON	TE SURVEY
		245293	B. WING			/25/13 per / 24/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	PKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	admission Minimun	ge 2 sis of dementia on the n Data Set (MDS) dated a Brief Interview for Mental	F 2	RECEIV		а 1913 — 1915 1914 — 1915 1917 — 1917 1917 — 1917 1917 — 1917 1917 — 1917 1917 — 1917 1917 — 1917 1917 — 1917 — 1917 1917 — 1917 — 1917 1917 — 1917 — 1917 1917 — 1917 — 1917 — 1917 1917 — 1917 — 1917 — 1917 1917 — 1917 — 1917 — 1917 — 1917 1917 — 1917 — 1917 — 1917 — 1917 — 1917 1917 — 1
	Status (BIMS) scor cognitive impairme complete the additi	e of 2, indicating severe nt. R222 was unable to onal mental status exam to making skills due to		NOV 2.5 20 COMPLIANCE MONITORI LICENSE AND CERTI	NG DIVIS	ION /1 - 2013 21 - 24 - 2 24 - 24 - 2 24 - 2391
	admission MDS da score of 99 indicati the assessment, ar	s of Alzheimer's disease on the ted 8/26/13. R214 had a BIMS ng he was unable to complete nd had severely impaired daily ills and rarely or never made				
	incident was report nursing (DON). The submitted 10/4/13.	roximately 9:00 a.m. the ed to the SA by the director of e investigative report was The incident was not reported rely (five days later).				
	On 10/24/13, at 12 verified the report v SA.	:36 p.m. the administrator was submitted late report to the	•			an a
	a fairly new nurse on abuse prevention "I think it just didn't heard about it in m right away." The D	56 p.m. the DON stated it was who had received the training on and reporting in orientation. cross her mind, so when we orning report, we called it in ON did acknowledge the report				
	was submitted late 483.13(c) DEVELC	to the SA. DP/IMPLMENT		226 F226		12-4-13
		evelop and implement written		 * All allegations of a for resident R222 will reported immediately to 	be	

		245293	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CON			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 10/25/13 per 10/24/2013	
	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 1011	
	LIVINGCENTER - HO	OPKINS		1	SECOND AVENUE SOUTH PKINS, MN 55343		
(4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	and misappropriation This REQUIREMEN by: Based on interview facility failed to ensight abuse were reporting agency (SA) for 1 of for reportable even Findings include: A review of the fact Procedures Regard Reporting of Allege State Laws Involvin Unknown Source in Minnesota State Vin Requirements date Mar 2012, revealed section B, noted the whether the incident section and under a facility to look at the and attempts of ab sexual, physical ar resident to residen harm occurred. A review of the even and going forward abuse.	lures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced v and document review, the ure all allegation of sexual ng immediately to the State or 4 residents (R222) reviewed ts. lity policy titled Policies and ding Investigation and ed Violations of Federal or ng Maltreatment, or Injuries of n Accordance with Federal and		226	<pre>State Agency. * All allegations of abu for all vulnerable adults residing in the facility be reported immediately the State Agency. * All facility staff hav been educated on the requirement of immediate reporting of all alleged resident abuse under the Vulnerable Adult Law. A facility staff have been educated on the facility procedures to encompass immediate reporting of a alleged abuse. * Monitoring to ensure compliance will be condu by the DNS through the vulnerable adult reporti and tracking logs maintai by the facility. * The facility QAPI committee will review the status of immediate vulnerable adult reportir quarterly for further recommendations. * The date of completion 12-4-13.</pre>	s will to ve ll 's ll .ned .ned	
			711	Faci	lity ID: 00872 If continua	ation shee	et Page 4 of 57
M CMS-25	67(02-99) Previous Version	S ODSOIETE EVENT ID. ENN	(11	Faci		ation shee	traye 40107

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/25/13 per <u>10/24/2013</u>	
		245293	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 725 SECOND AVENUE SOUTH		
GOLDEN	LIVINGCENTER - H	OPKINS		HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 226	on the ACU (mem assistant [NA] rep practical nurse [LF sitting on a bed in R222. R214 had h R222. The residen would be best to h residents got up a advanced dement and cannot be intu- sustained injuries concluded with ac recurrence: include help staff monitor attempting to kee each other and en programing. The R214 to sit togeth The plan lacked a	age 4 ory care) unit the "nursing orted to charge licensed PN] that R214 was observed an empty room alongside his hand down the pants of nts were told by the NA that it eave the room and both and left. Both residents have the nonsensical conversation erviewed, neither resident "The investigative report thom taken to prevent led 15 minute checks of R214 to his whereabouts. The staff are p R214 and R222 apart from ngaged in the activity staff are also allowing R222 and her only in a supervised setting. a specific time limit of how long servations were to be	F 2	26		
	admission Minim 9/19/13. R222 ha Status (BIMS) sc cognitive impairm complete the add determine decision	nosis of dementia on the um Data Set (MDS) dated d a Brief Interview for Mental ore of 2, which indicated server nent. R222 was unable to litional mental status exam to on making skills due to sorganized thinking.				
	admission MDS score of 99 which complete the ass	sis of Alzheimer's disease on the dated 8/26/13. R214 had a BIMS n indicated he was unable to sessment, and had severely scision making skills and rarely or sions.				
	On 9/30/13, at a	oproximately 9:00 a.m. the				
ORM CMS-	2567(02-99) Previous Versi	ons Obsolete Event ID: EKK7	11	Facility ID: 00872	If continuation sh	ieet Page 5 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245293	B. WING			10/25/13 per 6 	
	PROVIDER OR SUPPLIER	PKINS		72	REET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE SOUTH OPKINS, MN 55343		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	incident was reportenursing (DON). The submitted 10/4/13. to the SA immediate On 10/24/13, at 12: that failed to meet for reviewed with the advised to the set of the	ed to the SA by the director of investigative report was The incident was not reported	F	226			
F 242 SS=D	a fairly new nurse v on abuse preventio "I think it just didn't heard about it in me right away." The DC facility was a late in 483.15(b) SELF-DE	who had received the training n and reporting in orientation, cross her mind, so when we prning report, we called it in DN did acknowledge that the reporting to the SA. ETERMINATION - RIGHT TO	F	242	F 242		12-4-13
	schedules, and hea her interests, asses interact with memb inside and outside	he right to choose activities, alth care consistent with his or assments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that e resident.			 * The residents R113 and will have their preferenc assessed and accommodated bathing. * All residents will hav their preferences assesse and their requests for bathing accommodated. * The Clinical Nurse 	es for e d	
	by: Based on observa review, the facility f preferences were a	NT is not met as evidenced tion, interview, and document failed to ensure resident accommodated for bathing for 113, R15) reviewed for choices			Managers have been educat on the revised Resident Preference Questionnaire the schedules for complet to ensure resident preferences are accommoda * Monitoring to ensure compliance will be conduc through random resident satisfaction audits compl by the Licensed Social	and ion ted. ted	

Facility ID: 00872

If continuation sheet Page 6 of 57

PRINTED: 11/13/2013

DEPARTMENT	OF	HEALTH	AND	HUMAN	SERVICES
CENTERS FOR			& MF		SERVICES

PRINTED: 11/13/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION	COM	SURVEY PLETED
		245293	B. WING				25/13 per 24/2013
	PROVIDER OR SUPPLIER	OPKINS	STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	or shower in a wee R113 informed star one bath during the preference was no During an interview 9:52 a.m. the resid regarding how man showered during a take a shower "onl explained his prefe a week a shower", through his life price explained he want times a week, he clean", at times has movement", and n	of having more than one bath k was not accommodated. f he wanted to have more than e week; however, her t honored. v with R113 on 10/22/13, at ent stated he had "no choice" ny times he bathed or week. R113 stated he could y once a week". R113 erence was to take "three times as he used to do so previously or coming to the facility. R113 ed to take shower at least two stated he "was not always id "accidents with bowel ot being clean all the time		242	Workers. * The facility QAPI committee will review the status of the resident satisfaction audits quart for further recommendation * The date of completion 12-4-13.	erly ns.	
	told staff about was staff "didn't listen" R113 was interview a.m. when he state once a week both clean." R113 also his preference of I wanted to shower choice. Although R113's st Data Set (MDS) d cognition was sev for Mental Status interviews on 10/2 answered the interview	te a bit. R113 also stated he nting more often showers, but to him, so he just gave up. wed again on 10/23/13, at 9:21 ed again taking shower only ered him because he "didn't feel stated nobody asked him about now many times a week he or a bath, and he felt he had no ignificant change Minimum ated 8/5/13, indicated his erely impaired (Brief Interview or BIMS score was 6), during :2/13, and on 10/23/13, R113 rview questions consistently. 3 needed total assistance of hing needs.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00872

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG	COM	PLETED
		245293	B. WING			25/13 per 24/2013
AME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE	
OLDEN	LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 242	Continued From pa	ae 7	F 2	42		
	The Quarterly Inter dated 8/5/13, Clinic	disciplinary Resident Review al Health Status dated lude resident activities of daily				e e e e e e e e e e e e e e e e e e e
	Progress Note date	er's Care Unit) Psychosocial d 8/24/13, 5/18/13, and ude preference assessment.				
	and last revised on choices with cares'	oning care plan dated 9/8/10, 10/13, indicated "Encourage ', however the care plan did nt's choice regarding bathing				
	frequency. Per the diagnosed with der	plan of care, R113 was nentia with plan to long term al ecured Alzheimer's unit.				
 注か。 - 私知道	registered nurse (F 10/23/13, at around	ger of the ACU unit, also RN)-C was interviewed on d 10:55 a.m. RN-C verified athing schedule once a week,				1
1993) 1	and explained resid was completed upo started only two ye	dent's preference assessment on admission, which was ars ago. The RN-C verified				
	assessment might since he has been years. The RN-C for resident was scheo	stated a preference have not been completed in the facility for over three urther explained that every duled for once a week shower				
	once a week show	resident preferred more than er, it was up to the resident or bring that into the staff's				
	shower in a week	of having more than one bath o was not accommodated. R15 wanted to have more than one				

If continuation sheet Page 8 of 57

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		LETED
		245293	B. WING _		-10/2	25/13 per (4/2013 -
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	Continued From pa was not honored.	ige 8	F 24	42		
	11:18 a.m. R15 exp saw only some sha stated he had "no o times he bathed or stated he could tak week." R113 explai "take a bath at leas explained once a w for him, it made hin due to his eye sigh with the bathing pro to staff member he few days later the o him that was not pro given him an expla	in his room on 10/22/13, at blained he was legally blind, dows. During interview R15 choice" regarding how many showered during a week. R15 e a shower "only once a ined his preference was to at two times a week." R15 also veek shower was "not enough" n feel "dirty". He also stated t he needed staff's assistance bccss. R15 also stated he told e wanted more often showers, a clinical manager came and told ossible, however he have not unation. R15 further explained m about his bathing frequency				
	R15's cognition was score was 9). Per assistance of one R15's diagnoses ir	DS dated 9/26/13, indicated as moderately impaired (BIMS the MDS, R15 needed physica staff with bathing needs, and included: hypertension, disorder and schizophrenia.	Ι			
	10/18/12, noted R shift bath preferen	erence Questionnaire dated 15's day shift versus evening ce was assessed, however the not contain question regarding quency preference.				
	indicated "Encoura "Assist of 1 w [with	ficit care plan dated 10/4/13, age choices with cares", and n]/ shower/bath as scheduled". not indicated R15's choice frequency.				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/13/2013 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	re survey MPLETED /25/13 per G
		245293	B. WING _			124/2013
	PROVIDER OR SUPPLIER	DPKINS	STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343			
(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 CORRE	IOULD BE	(X5) COMPLETION DATE
F 242	Continued From pa	-	F 24	42		
	nurse (LPN)-B was 11:43 a.m. and stat assessed upon add and acknowledged asked about their s preference. The LF formal assessmen shower/bath freque	er, also licensed practical interviewed on 10/23/13, at ted residents preferences were mission, at care conferences, residents were not "Officially" shower/ bath frequency PN-B verified there was no t regarding resident's ency preference. The LPN-B er if he had a discussion or not shower schedule.		·		
F 279 SS=D	10/24/13, at 11:43 Resident Preferen by her two years a questionnaire did r resident's shower/	k)(1) DEVELOP		79 F 279 * The plan of care fo	or R56	12-4-13
	A facility must use to develop, review comprehensive pla The facility must d plan for each resic objectives and tim medical, nursing, a needs that are ide assessment. The care plan must to be furnished to	the results of the assessment and revise the resident's		 The plan of care for is developed to include ambulation guidelines recommended upon disch from therapy. The plan care for R214 is devel include psychotropic medication use. The plans of care for residents requiring ambulation programs has developed to encompass current ambulation pro The plans of care for residents receiving psychotropic medication 	de the as harge an of loped to for all ave been s the ogram. all	

Facility ID: 00872

		AND HUMAN SERVICES				FORM /	11/13/2013 APPROVED
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-0391 SURVEY PLETED
		245293	B. WING				25/13 per
NAME OF F	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LIVINGCENTER - HO	DRING		72	25 SECOND AVENUE SOUTH		
JOLDEN	LIVINGCENTER - IIC	JE KING		н	OPKINS, MN 55343		
(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 APPROPF DEFICIENCY)	BE	.(X5) COMPLETION DATE
F 279	psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including under §483.10(b)(4) This REQUIREMEI by: Based on observareview, the facility f for ambulation reco 1 resident (R56) reservices. In addition a care plan for psyce resident (R214). Findings include: Ambulation: R56 was admitted Nursing Home Visi R56 had diagnoses rhabdomyolysis, hi weakness. R56's c of an ambulation p recommendations. R56's Minimum Da indicated R56 required addition, the MDS resident's ability to walk/ambulate in the Although the care	to the facility on 7/12/13. The the note dated 7/15/13, noted s which included story falls, deconditioning and are plan lacked development rogram per therapy		279	been developed. * Clinical Nurse Managers have been educated on the requirement to develop a co- plan to encompass ambulati- recommendations for all residents requiring an ambulation program. The education also included th- requirement for all ambulation programs to be documented on the TAR and incorporated on the nursi- assistant team sheets. Clinical Nurse Managers and Licensed Social Workers have been educated on the requirement to develop a co- plan for all residents receiving psychotropic medications. * Monitoring to ensure compliance will be conduct through random audits of co- plans, TARs, and team sheef for those residents required an ambulation program. Random audits will also be completed of the care plan for residents receiving psychotropic medications. * The facility QAPI committee will review the results of the ambulation psychotropic medication audits quarterly for furti- recommendations. * The date of completion will be 12-4-13.	ted care ted care ets ring e ns and her	
	staff to assist R56	with transfers, ambulation, bed ing and range of motion. Care					

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	TE SURVEY MPLETED
		245293	B. WING)/25/13 per G /24/2013
	PROVIDER OR SUPPLIER	OPKINS		STREET ADDRESS, CITY, STATE, ZIP CO 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
	up to 50 feet." On distance from R56' table and stated it each direction. The the physical therap ambulate R56 to a care still directed th feet. On 10/23/13, at 7: (NA)-A and NA-B v stand with a transfe transfer NA-A cueo NA-B guided R56's rest. During transfe shuffling steps and then sat down in th -At 8:13 a.m. NA-E	tinue to ambulate with assist 10/25/13, PT paced off the s room to the dining room was approximately 140 feet e care plan failed to address y (PT) recommendation to nd from meals as the plan of the staff to ambulate R56 50 55 a.m. nursing assistant vere observed to assist R56 er belt and walker. During d R56 to turn to his right side as s arm to the wheelchair arm er R56 stood, had short, t walked approximately five feet		279		
	ambulated R56 fro	10 p.m. NA-A stated she om outside his room to the e lunch but had not ambulated e meal.				
	nurse manager (L communication br be ambulated per discharge from the transferred from 1 on to state that wh LPN-B had noted assignment sheet 10/18/13, LPN-B h feet to see his abi	2:40 p.m. licensed practical PN)-B stated there was a eakdown that R56 needed to recommendation made upon erapy, when R56 was West to 2 East. LPN-B went nen R56 transferred to unit, on the 2 East nursing assistant s R56 was ambulating and on nad ambulated the resident 100 lity. In addition, LPN-B verified umentation of R56 ambulating				

Facility ID: 00872

If continuation sheet Page 12 of 57

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PRINTED: 11/13/2013

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	CO	re survey Mpleted)/25/13 per
		245293	B. WING	<u>ر</u>		 24/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
GOLDEN	LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	would take respons ambulation program implemented upon On 10/25/13, at 7:2 Unit (TCU)/1 West (RN)-A stated R56 admission to TCU, TCU he had chang She stated "I knew	0/18/13. LPN-B stated he sibility for not ensuring the n recommended by PT was transfer to 2 East on 9/26/13. 25 a.m. the Transitional Care registered nurse manager has used a lift to transfer on towards the end of his stay in led to assist of 1 with transfer. he was walking with PT but I	F 2	279		
	nursing." RN-A furd ambulating, it woul normally if physica resident was supp be put on the treat (TAR)." RN-A furth copy of the team s TCU to look back	er if he was walking with her stated "if someone were d be on the team sheet; I therapy was completed and osed to be ambulated it would ment administration record er stated she did not have a heet from when R56 was at if R56 had been on a walking emained in TCU for nine days ed to 2 East.				
	"Usually when a re unit, social service nurse moved the r reported to the flo (CM) reported to t relay the team she remembered R56 gave a verbal repo stated she used th Kardex to report if basically everythir reported. RN-A we	01 a.m. RN-A again stated esident transferred to another e moved the belongings, the medications, the chart and our nurse. The clinical manager he CM of the receiving unit to eet information." RN-A vaguely s transfer and believed she ort to LPN-B. RN-A further he Point Click Care (PCC) if assistance was needed and ag on the team sheet was ent on to state "If the CM wasn" e it (the PCC Kardex) on his				

		AND HUMAN SERVICES				FORM	: 11/13/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED /25/13 per
		245293	B. WIN	G			24/2013
	IAME OF PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CO		24/2013
	LIVINGCENTER - HO	OPKINS		725 S	ECOND AVENUE SOUTH		
OOLDLIN	LIVINGOENTER			НОР	KINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRE TA	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 13 18 a.m. LPN-B stated cares	F	279			
	provided to R56 inc one with transfer by (vascular ulcers on digit), and underly was to get him bac did remember getti LPN-B pulled up an	cluded transfers with assist o elt, working on wounds n left leg and right foot 2nd ing osteomyelitis. "The goal k to assisted living." LPN-B ing a verbal report from RN-A nd printed the PCC Kardex fo					
13 63-9 12-6	R56 which indicate one. LPN-B verified Kardex after transf	ed ambulation with assist of d he had not updated the PC fer.	C				
	(DON) verified the identify R56 was o per therapy recom stated she would e TAR, and team she information per the	34 a.m. the director of nursing care plan for R56 failed to n an ambulation program as mendation. The DON further expect to see the care plan, eet filled out with matching erapy recommendation. She B had not written the care pla					
	Psychotropic medi R214's Admission admitted to the fac which included Alz without behavioral was not developed	ication: Record indicated R214 was cility on 8/19/13, with diagnos cheimer's disease and demer disturbances. R214's care p d to identify risk factors, goals for the use of Seroquel (an	tia an				
	indicated: "SEROg [milligram] by mou ANTIPSYCHOTIC	onic Physician's Orders guel tablet Give 25 mg uth two times a day for " with an 8/30/13, start date.					
	have not any beha	DS dated 8/30/13, noted R21 aviors such as delirium, organized thinking, altered le	vel		ID: 00872 If	continuation shee	t Page 14 of 57

TATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245293	B. WING			0/25/13 per /24/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa of consciousness, o verbal, physical bel towards others.	ge 14 or any other behaviors such as navioral symptoms directed	F 27	79		
	dated 8/30/13, indic behaviors r/t [relate medication to mana CAA did not indicat had.	e Area Assessment (CAA) cated "resident displays d to] Alzheimer's and receives age and treat condition." The e what kind of behaviors R214				
	The care plan lack	ated 8/19/13, was reviewed. ed indication for the Seroquel risks, goals, target behaviors, gical interventions identified.				
	10/24/13, at approx explained when sh antipsychotic medi information regard ordered, side effect monitoring, pharma non-pharmacologie to psychologist as R214's record and	ager was interviewed on kimately 1:10 p.m. RN-C e wrote a care plan for cation use she usually included ing: medication use as t monitoring, target behavior acist consults, cal interventions, and referrals needed. RN-C reviewed confirmed the lack of care ychotropic medication				
F 282	2013, noted in the section "Licensed Plan of Care follow antipsychotic med concerns."	agement Guidelines revised in Assessment/Care Planning nursing staff completes the ving identification of ication usage or behavioral RVICES BY QUALIFIED ARE PLAN	F 2	282 F 282		12-4-13

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OM		APPROVED 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COM	E SURVEY PLETED
		245293	B. WING	;			/25/13 per 24/2013
AME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				72	5 SECOND AVENUE SOUTH		
OLDEN	I LIVINGCENTER - HO	OPKINS		н	OPKINS, MN 55343		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	must be provided b accordance with ea care. This REQUIREMEN by: Based on observat interview, the facilit as directed by the p (R39, R56) in the s upon staff for nail of failed to follow the of 1 of 1 resident revis Findings include: R39 on 10/22/13, a have approximately on both hands. The a buildup of browni During continuous from 6:46 a.m. thro observed to have h fingernails on both	ge 15 led or arranged by the facility y qualified persons in ich resident's written plan of NT is not met as evidenced tion, document review and y failed to provide nail cares olan of care for 2 of 3 residents ample who were dependent ares. In addition, the facility care plan for fluid restriction for ewed for dialysis (R97). It 10:12 a.m. was observed to y half (1/2) inch long fingernails e nails were observed to have sh colored soil under the nail. observations on 10/23/13, ough 9:19 a.m. R39 was half inch long and soiled hands. At no time during the ail care offered or provided to		282	have been provided nail c as directed by the plan o care. The resident R97 h been provided fluid restriction as directed by the plan of care. * All residents will rec nail care as directed on their plan of care. All residents will receive fl restrictions as directed their plan of care. * All nursing staff have been educated on the requirement to provide n care as directed by the of care. Licensed nurses will be educated on the requirement to document t status or refusal of nail care on the Comprehensive Skin Assessment forms. A nursing staff and dietici will be educated on the requirement to follow the plan of care for resident requiring fluid restricti and the facility protocol communicate and document adherence to the fluid restrictions.	f as y eive uid by ail plan he ll ans sons	
	The Admission Record dated 6/1/13, indicated R39's diagnoses included Alzheimer's disease and dementia without behavioral disturbance. A blue binder labeled The Team 2 Assignment and Team Sheets contained nursing assistant (NA) assignment sheets (used to direct individual resident care needs). The sheet identified R39			-	* Monitoring to ensure compliance will be conduc through random grooming/n care audits in conjunctio with grooming care plan audits and Comprehensive Assessment audits. Rando audits will also be condu for residents receiving f	ail n Skin m	

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO	2: 11/13/2013 APPROVED 2: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			re survey MPLETED)/25/13 per (
		245293	B. WING			124/2013
	PROVIDER OR SUPPLIER	DPKINS		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	transfers, independ walker, was contine bladder and require special instructions "Alert X2 [times two Grooming, & Dress refuses." R39's care plan for 10/28/11, identified deficit. The care plan & PRN [as needed On 10/23/13, at 11 nurse manager (LF directed to offer national On 10/24/13, at 2: (DON) stated her en residents well groom residents well groom residents were ress mental illnesses. If better job" docume natic care was not provide R56 was not provide R56 was observed during the evening subsequent days of 10/23/13, during of fingernails remained during the observed	was independent with lent with ambulation with a ent of bowel, incontinent of ed a "Toileting Plan." The section of the sheet directed, o]. Assist w/ [with] Bathing, sing, Reapproach [sic], if he self-care deficit dated R39's risks associated with an directed, "Nail care weekly]." :11 a.m. the licensed practical PN)-B verified the care plan il care weekly and as needed. 11 p.m. the director of nursing expectation was to have all omed. DON stated "a lot" of istive with cares and had other DON stated staff should "do a enting in the space provided; if provided, was refused and if	F 2	82 restrictions are being provided per care plan. * The facility QAPI committee will review to results of the care pla grooming audits and flue restriction audits quar for further recommendat * The date of completion will be 12-4-13.	the nn nid terly tons.	
	R56. R56's 60-day Mini 9/11/13. identified	mum Data Set (MDS) dated R56 required limited physical				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FE SURVEY MPLETED
				NG)/25/13 per
		245293	B. WING _			<u> 24 2013</u>
ME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
OLDEN	LIVINGCENTER - HO	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION DATE
F. 282	The Comprehensiv 7/27/13, indicated F	vith personal hygiene needs. e Assessment Summary dated R56 required assist of one with ers, dressing, toileting, bathing	F 2	82		
	with physical function related to rhabdom and congestive heat well dressed, groom nursing assistant a 1-Apha" directed R bathing, grooming, Shower Schedule" shower/bath on ever Review of the July Comprehensive St had nail care compressive addition nail care h times with no reason completed on 7/23	ed 7/14/13, identified resident oning and self-care deficit yolysis, glaucoma, anemia, art failure. The Goal "will be med and free of odor." The ssignment sheet " Team .56 required assist with and dressing. The "2 E South directed R56 to receive a ening shift (PM) on Monday. through October 2013 kin Assessment indicated R56 bleted 7/30/13 and 10/7/13. In had been circled " No " three on as to why nail care was not /13, 10/14/13, 10/21/13, there ation of nail care provided or 30/13.				
	expectation was all done per care plan residents to get qu stated if he saw a shaven or needing	36 a.m. LPN-C stated his I resident's cares were to be and he expected all the ality care. In addition, LPN-C resident during the day not grooming he would remind the to make sure it is done by the				
	On 10/23/13, at 9: completed providir would check later	54 a.m. NA-A stated she had ng morning cares R56, but and toilet him.				
	On 10/22/12 of 11	:14 a.m. LPN-C verified the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	E SURVEY IPLETED /25/13 per
		245293	B. WING		10	/23/13 per /24/2013
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 725 SECOND AVENUE SOUTH HOPKINS, MN 55343	DDE		
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	little long and need is done on the resid needed to check an see the nails were he remembered sta and then stated " I my nose" then loc with a smile and st On 10/24/13, at 12 care was done were residents and if a r nails long then wor verified that R56 di indicated a wish fo verified R56's nail 10/14/13 and 10/2 documentation as	d soiled and stated "they are a to be clipped" stated nail care dent's bath day but aides nd do it daily as soon as they long. Additionally R56 stated aff cutting his nails in the past like to have them long to pick oked at surveyor and nurse	F 28	32		
χ. 	resident with groor care. On 10/24/13, at 2: expectation was to groomed. DON sta resistive with care illnesses in the un	ed he expected staff to assist ming according to the plan of 11 p.m. the DON stated her b have all resident's well ated "a lot" of residents were s and had other mental it. DON further stated "staff job documenting in the space				
	provided; if nail ca refused and if staf	re was not provided, was f re-approached the resident."				
	policy for licensed included diabetics administration rec nurses to do. The	34 a.m. the DON stated their staff to do nail trimming only , it would be on the treatment ord (TAR) for the licensed DON further stated the policy sidents on Coumadin.				

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION	CO	TE SURVEY MPLETED
		245293	B. WING)/25/13 per /24/2013
	ROVIDER OR SUPPLIER	DPKINS		725 SEC	ADDRESS, CITY, STATE, ZIP COE COND AVENUE SOUTH NS, MN 55343	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 19	F	282			
	trimming of nail car and had been signed was not on the TAF units. DON stated say 2 East on the co stated was not sure	00 a.m. the DON verified re was on the September TAR ed off once on 9/13/13, but R after resident transferred "I don't know why that would tate indicated." DON further e why the TAR was different ed from one unit to the other.					
	disease, congestiv review of the curre orders. The physic noted R97 had a le dialysis Mondays a 1200 milliliter (ml) not ensure physicia were implemented	s including end stage renal e heart failure and diabetes pe nt electronic physician's ian's order dated 6/17/13, eft arm shunt/fistula, was on and Friday, and R97 was on a fluid restriction. The facility did an ordered fluid restrictions and encouraged as indicated which potentially contributed to					
	R97's care plan las "Fluid restriction as	st revised on 10/4/13, indicated s ordered."	ł				Law y and the second seco
	noted the 1200 ml plan directed staff: - "Dietary Provide	s: Breakfast= 240 ml	e				
	ا - Supplements: Ne 240 ml	_unch= 240 ml Dinner=240 ml ephro 4 oz BID [twice daily] =					
	- Nursing Provides =60 ml	s: 7:00 med [medication] pass 11:30 med pass =60 ml 15:00 med pass =60 ml 20:00 med pass = 60 ml "					

Facility ID: 00872

If continuation sheet Page 20 of 57

TATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		245293	B. WING	NG	10/25/13 10/24/2013	
	PROVIDER OR SUPPLIER	240255		STREET ADDRESS, CITY, STATE, ZIP C		
	LIVINGCENTER - HO	PKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	e de la composition d Reference de la composition de la composit	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP	SHOULD BE COMPLET	
F 282	R97 was observed at 8:11 a.m. R97 dr apple/ cranberry jui	ge 20 eating breakfast on 10/23/13, ank approximately 240 cc ce and 240 cc hot tea. The ndicate R97 was on 1200 cc	F 2	82		
	R97 was observed 10:35 a.m., with a v bedside table.	in her room on 10/23/13, at white water pitcher on the				8913 V100 <u>2004</u>
	a.m. lying in the be pitcher on the beds plastic cup halfway interviewed at the t memory was bad, a she had been told order. R97 stated pitcher full with was	again on 10/24/13, at 9:19 d. There was a white water side table with an 8 ounce (oz.) full with water. R97 was ime, and explained her and she could not remember if about the fluid restrictions once a day staff bring a water ter. R97 also stated she only uldn't drink too much.				
	the resident was in a.m. and stated RS water in the white p needed. NA-D stat restriction. Review indicated "*Fluid re assignment sheet	is assigned to provide cares to terviewed on 10/24/13, at 9:19 97 was provided daily with bitcher, and received a refill as ed R97 was not on fluid of the care assignment sheet estrictions", however the care did not provide any additional g how much fluid staff could				
	a.m. and stated he head if R97 was or reviewed the elect record (MAR) and indication regardin	ewed on 10/24/13, at 10:07 e did not know off the top of his n fluid restriction. LPN-D ronic medication administration TAR, and did not find any g the fluid restrictions. LPN-D ew the physician's orders and				

 $r \in I$

AME OF PROVIDER OR SUPPLIER 725 SEC. OLDEN LIVINGCENTER - HOPKINS ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX F 282 Continued From page 21 F 282 found the 1200 cc fluid restriction order. The LPN-D verified the electronic MAR and TAR did not provide clear instructions regarding how much fluid nursing staff were supposed to administer to R97 in order to comply with the fluid restriction order. F 282 Review of R97's weights indicated the following: - 1/4/13: 135.2 pounds (#) - 2/4/13: 135.2 # - 1/4/13: 135.2 # - 3/4/13: 131.2 # - 4/2/13: 137.2 # - 6/3/13: 136.2 # - 5/2/13: 141# - 6/3/13: 136.2 # - 5/2/13: 141#	Image: teal state
AME OF PROVIDER OR SUPPLIER 725 SEC HOPKIN FOLDEN LIVINGCENTER - HOPKINS ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX TAG C F 282 Continued From page 21 found the 1200 cc fluid restriction order. The LPN-D verified the electronic MAR and TAR did not provide clear instructions regarding how much fluid nursing staff were supposed to administer to R97 in order to comply with the fluid restriction order. F 282 Review of R97's weights indicated the following: - 1/4/13: 135.2 pounds (#) - 2/4/13: 135.2 # - 3/4/13: 131.2 # - 4/2/13: 137.2 # - 5/2/13: 141.4 # - 6/3/13: 136.2 # - 7/5/13: 135 # - 8/2/13: 141.4 # - 9/2/13: 138 # - 10/11/13: 141.6 # - 10/4/13: 151.6 # F 282	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE
F 282 Continued From page 21 F 282 found the 1200 cc fluid restriction order. The LPN-D verified the electronic MAR and TAR did not provide clear instructions regarding how much fluid nursing staff were supposed to administer to R97 in order to comply with the fluid restriction order. Review of R97's weights indicated the following: - 1/4/13: 135.2 pounds (#) - 2/4/13: 135.2 pounds (#) - 2/4/13: 137.2 # - 6/3/13: 136.2 # - 3/4/13: 131.2 # - 8/2/13: 141.4 # - 6/3/13: 135.# - 8/2/13: 141.6 # - 10/1/13: 141.6 # - 10/1/13: 141.6 # - 10/1/13: 141.6 # - 10/11/13: 149# - 10/18/13: 151.6 #	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION- ROSS-REFERENCED TO THE APPROPRIATE DATE
 F 202 Commuted From page 21 found the 1200 cc fluid restriction order. The LPN-D verified the electronic MAR and TAR did not provide clear instructions regarding how much fluid nursing staff were supposed to administer to R97 in order to comply with the fluid restriction order. Review of R97's weights indicated the following: - 1/4/13: 135.2 pounds (#) - 2/4/13: 135.2# - 3/4/13: 131.2# - 4/2/13: 137.2# - 5/2/13: 141# - 6/3/13: 136.2# - 7/5/13: 135# - 8/2/13: 141.4# - 9/2/13: 138# - 10/1/13: 141.6# - 10/4/13: 151.# - 10/11/13: 149# - 10/18/13: 151.6# 	
- 1/4/13: 135.2 pounds (#) - 2/4/13: 135.2# - 3/4/13: 131.2# - 4/2/13: 137.2# - 5/2/13: 141# - 6/3/13: 136.2# - 7/5/13: 135# - 8/2/13: 141.4# - 9/2/13: 138# - 10/1/13: 141.6# - 10/4/13: 151# - 10/11/13: 149# - 10/18/13: 151.6#	
The registered dietician (RD) was interviewed on 10/24/13, at around 10:30 a.m. and explained the Fluid restriction plan was calculated between meals, supplements and medication administration. Per the RD the plan was placed in the intake and output book, and dietary staff was also provided with a copy. The RD also stated R97 was not supposed to receive water in the water pitcher for consumption; however the RD stated she had "removed a water pitcher yesterday from her room." The RD was not aware R97 was provided regularly with the water pitcher. The RD verified the water pitcher was 24 oz. (720 ml). The RD also stated she had noticed R97's weight had gone up slightly in the past several weeks, which could have been related to too	1: 00872 If continuation sheet Page 22 of

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MU		OMB	TED: 11/13/20 DRM APPROV NO: 0938-03	'ED
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED 10/25/13	ner G
		245293	B. WING			10/24/2013	•
	ROVIDER OR SUPPLIER	DPKINS		725	EET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE SOUTH PKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETI DATE	ION
F 282	much fluids intake. LPN-B, was intervie	ewed on 10/24/13, at 10:55 7 was not supposed to receive	F 2	282			
	The DON was inter p.m. and explained orders were comm through team assig the plan was outline electronic (e) MAR expected to follow DON also explaine how much fluid was medication adminis R97's e-mar and vo	viewed on 10/24/13, at 12:51 a resident's fluid restriction unicated to the nursing staff nment sheet for the aids, and ed for the licensed staff on the . Per the DON staff was also the fluid restriction plan. The d the e-MAR had to reflect s to be given with each stration. The DON reviewed erified that although it indicated mI fluid restriction, there was					918 919
F 309	fluid restrictions are Responsibility for fl between the Dining department". 483.25 PROVIDE	n, undated, policy indicated "All e ordered by the physician. luid allotment is divided g Services and the Nursing CARE/SERVICES FOR		309	F 309	12-4-	13
SS=D	provide the necess or maintain the hig mental, and psych accordance with th and plan of care.	EING It receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in the comprehensive assessment NT is not met as evidenced			 * Resident R97 has been provided the care and services related to the requirement for fluid restriction. * All residents requiring fluid restrictions will be provided the care and services required to maintai the fluid restrictions. * All nursing staff and dieticians have been educated 		

If continuation sheet Page 23 of 57

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	e survey IPLETED /25/13 per
		245293	B. WING			10/	24/2013
	PROVIDER OR SUPPLIER	OPKINS		72	REET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE SOUTH OPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	review, the facility	tion, interview and document failed to provide care and fluid restrictions for 1 of 1	F	309	on the facility protocols communicate and document adherence to resident flu restrictions. The educat included the requirement outline fluid restriction the plan of care, the nume assistant team sheet, and	id tion to ns on rsing	
	fluid restrictions w	ensure physician's ordered ere implemented and n potentially have contributed to			fluid administration play meals and medication pass outlined on the e-MAR. * Monitoring to ensure compliance will be condu through random audits of	n for ses cted care	11 68.47 14 - 1473 15 - 1213 16 - 1 14 - 1
	Review of the curr orders indicated R end stage renal di and diabetes. The 6/17/13, noted R9 was on dialysis M	rent electronic physician's 197 had diagnoses including sease, congestive heart failure physician's order dated 7 had a left arm shunt/fistula, ondays and Friday, and R97 iter (ml/cc) fluid restrictions.			<pre>plans, team sheets, and MARs for residents recei fluid restrictions. * The facility QAPI committee will review th results of the fluid restriction audits quart for further recommendati * The date of completic</pre>	ving e erly ons.	
	at 8:11 a.m. R97 (apple/cranberry ju	d eating breakfast on 10/23/13, drank approximately 240 cc uice and 240 cc hot tea. R97's t indicate R97 was on 1200 cc			will be 12-4-13.		
	R97 was observe 10:35 a.m., with a bedside table.	d in her room on 10/23/13, at a white water pitcher on the					
	a.m. lying in the be pitcher on the bee plastic cup halfwa interviewed at this memory was bad was told before a	d again on 10/24/13, at 9:19 bed. There was a white water dside table with an 8 ounce (oz.) ay full with water. R97 was s time, and explained her , and could not remember if she bout the fluid restrictions orders er once a day a water pitcher full	1		acility ID: 00872 If continu		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT CON	E SURVEY
	JORNEOHION		B. WING			/25/13 per /24/2013 -
	ROVIDER OR SUPPLIER	245293		STREET ADDRESS, CITY, STATE, ZIP C		24/2013
	LIVINGCENTER - HC	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	she should not drin The nursing assista to provide cares to on 10/24/13, at 9:1 provided daily with and received refill a was not on fluid res assignment sheet i however did not pro- regarding how much The licensed pract interviewed on 10/2 he did not know off	o stated she only knew that k too much. ant (NA)-D, who was assigned the resident was interviewed 9 a.m. and stated R97 was a water in the white pitcher, as needed. NA-D stated R97 strictions. Review of the care indicated "*Fluid restrictions", ovide any additional directions ch fluid staff could provide R97 ical nurse (LPN)-D was 24/13, at 10:07 a.m. and stated f the top of his head if R97 was		09		
	electronic medicati (MAR) and treatme (TAR), and did not the fluid restriction the physician's ord restriction order. T electronic MAR an instructions regard staff supposed to a	b. LPN-D reviewed the ion administration record find any indication regarding s. LPN-D proceeded to review lers and found the 1200 cc flui the LPN-D verified the d TAR did give clear ling how much fluid nursing administer to R97 in order to iid restriction orders.	d			the state
	- 1/4/13: 135.2 pou - 2/4/13: 135.2# - 3/4/13: 131.2# - 4/2/13: 137.2# - 5/2/13: 141# - 6/3/13: 136.2# - 7/5/13: 135#	reights indicated the following: unds (#)				
	- 8/2/13: 141.4# - 9/2/13: 138# - 10/1/13: 141.6#					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			(X3) DA). 0938-0391 TE SURVEY MPLETED
		245293		NG	1	0/25/13 per
	PROVIDER OR SUPPLIER	243233		STREET ADDRESS, CITY, STATE, ZIP CO		124/2013
	I LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Continued From pa - 10/4/13: 151# - 10/11/13: 149# - 10/18/13: 151.6# - 10/21/13: 150.6#	age 25	F 3	09		
	10/14/13, indicated restriction, and R9 from her UBW [usu	utritional assessment dated R97 was on 1200 cc fluid 7's weights were "increased ual body weight] by a few elated to] noncompliance with s]."				
	R97's care plan las "Fluid restriction as	st revised on 10/4/13, indicated ordered."				
	noted the 1200 cc plan directed staff:	ration plan dated 6/18/13, per day fluid restriction and the				
, T		Breakfast= 240 ml Lunch= 240 ml Dinner=240 ml phro 4 oz BID [twice daily] =				
	240 ml	: 7:00 med [medication] pass				
	1	1:30 med pass =60 ml 5:00 med pass =60 ml 0:00 med pass = 60 ml				19 - A.
		card for breakfast, noon and lude any information regarding				
	10/24/13, at aroun Fluid restriction pla meals, supplemen	tician (RD) was interviewed on d 10:30 a.m. and explained the an was calculated between ts and medication r the RD this plan was placed in				

TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY
PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG)/25/13 per
		245293	B. WING _		10	24/2013
ME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	. *
OLDEN	LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 309	Continued From pa	age 26	F 3	09		
		a copy. The RD also stated	1 01			
	R97 was not suppo	osed to receive water in the				
	"removed a water p	onsumption, however she have bitcher yesterday from her				
1	room." The RD was	s not aware R97 was provided				
	verified was 24 oz.	vater pitcher, which the RD (720 ml). The RD also stated				and the second
1. · · ·	she have noticed F	(97's weight have gone up				
	slightly in the past	several weeks, which could to too much fluids intake.				일 <u>- 관</u> 습 - 관람
	on 10/24/13, at 10:	urse manager was interviewed 55 a.m. and stated R97 was ceive water pitcher in her				
	The director of nur	sing (DON) was interviewed on				
i	10/24/13, at 12:51	p.m. and explained a triction orders were				1 11. X
	communicated to t	the nursing staff through team				
	assignment sheet	for the aids, and the plan was ensed staff on the electronic (e)				
	MAR. Per the DOM	N staff was also expected to				$\left \frac{1}{2} \right = \left \frac{1}{2} \right \left \frac{1}{2} \right $
	follow the fluid res	triction plan. The DON also AR had to reflect how much				
	fluid was to be give	en with each medication				
	administration. The	e DON reviewed R97's e-mar Ithough it indicated R97 was on	-			
	1200 cc fluid restr	iction; there was no outlined				
	plan for nurses to	follow.				
	The Fluid restriction	ons undated policy indicated "Al	1			
	fluid restrictions ar	re ordered by the physician.				
	between the Dinin	fluid allotment is divided g Services and Nursing				
F 311	department." 483.25(a)(2) TRE	ATMENT/SERVICES TO	F	311 F 311		12-4-13
SS=D	IMPROVE/MAINT	AIN ADLS	5 3	* The residents R39	and R56	

SURVEY LETED	CONSTRUCTION (X3) DATE COMP		1 ' '	& MEDICAID SERVICES	OF DEFICIENCIES	TEMENT
25/13 pe	10/	.DING	A. B	IDENTIFICATION NUMBER:	FCORRECTION) PLAN O
4/2013	10/2		В. V	245293		
	REET ADDRESS, CITY, STATE, ZIP CODE	1	1		PROVIDER OR SUPPLIER	AME OF F
	5 SECOND AVENUE SOUTH	725				1
· · · ·	OPKINS, MN 55343	НО)PKINS	I LIVINGCENTER - HC	JOLDEN
(X5) COMPLETION DATE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)) FIX .G		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(FACH DEFICIENCY	(X4) ID PREFIX TAG
	have been provided nail care as directed by the plan of	- 311		age 27	Continued From pa	F 311
	care. The resident R56 has			the enprendiate treatment and		
	been provided ambulation as			the appropriate treatment and in or improve his or her abilities	A resident is given	
	recommended by therapy. * All residents will receive			aph (a)(1) of this section.	services to maintail	
	* All residents will receive nail care as directed on			apri (a)(1) of this section.	specified in paragra	
	their plan of care. All					
	residents will receive			NT is not met as evidenced	This REOUREME	
	ambulation assistance as				by:	
3. 17.81	directed on their plan of			ation, interview, and document	Based on observa	
	care and as recommended by			failed to provide assistance for	review, the facility f	ī
a si	therapy.			(39, R56) who were unable to	2 of 3 residents (R	
	* All nursing staff have			nplete nail cares. In addition,	independently com	
	been educated on the		1	ensure ambulation was	the facility failed to	
i di anti-	requirement to provide weekly			mended by therapy for 1 of 1	provided as recom	
	and as needed nail care to all residents. Education			iewed for ambulation.	resident (R56) revi	1
	will include the requirement					
	for licensed nurses to				Findings include:	
	document weekly the		-		NL 11	
	completion or refusal of			ided assistance with nail cares.	Nail care:	
	nail care on the			ded assistance with han earlier.	R39 was not provid	
	Comprehensive Skin Assessment			0:12 a.m. R39 was observed to	$O_{\rm D} = 10/22/13$ at 10	
	Forms. All nursing staff	10. U	s	ly half (1/2) inch long fingernails	bave approximate	
44	have been educated on the		-	ne nails were observed to have	on both hands. Th	
	requirement to have resident			hish colored soil under the nail.	a buildup of brown	
	ambulation programs on the					
	plan of care, documented when			s observations, the following	During continuous	
	completed on the e-TAR, and				was observed:	
	incorporated on the nursing assistant team sheets.			:46 a.m. R39 was observed to	On 10/23/13, at 6:	
				e day. The fingernails on	be dressed for the	
	* Monitoring to ensure compliance will be conducted		-	remained long and soiled on	both R39's hands	
	through random grooming/nail		~	edges of the nails appeared	both hands. The e	
	care audits in conjunction		e	en. R39 wheeled himself into the	jagged and uneve	
	with grooming care plan			used the tollet.	shower room and	
	audits and Comprehensive Skin			ile R39 wheeling himself down	- At 6:56 a.m. whil	
	Assessment form audits.		,	toileting, a nursing assistant	the hallway after to	
	Random audits will also be			9's shirt was soiled and verbally	(NA)-C noted R39	
· · · · · · · · · · · · · · · · · · ·	conducted of care plans,			to change his shirt. R39 , "No." The licensed practical	encouraged nim to	

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: FORM A OMB NO.	PPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		LETED
		245293	B. WING			25/13 per 4/2013 -
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - HO	DPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE	(X5) COMPLETION DATE
F 311	and directed to NA- [R39] cools down." wheelchair near the unit. - At 7:00 a.m. nursi	ge 28 N)-B was present at the time C to "re-approach after he R39 remained in the e television (TV) area of the ng assistant (NA)-C stated privince R39 to change his	F :	TARs, and team sheets f those residents requiri ambulation program. * The facility QAPI committee will review t results of the grooming ambulation audits quart for further recommendat	ng an he and erly ions.	2012 - 2012 - 2012 2012 - 2012 2012 - 2012 - 2012 - 2012 2012 - 2012 - 2012 - 2012 - 2012 2012 - 2012 - 2012 - 2012 - 2012 - 2012 2012 - 2012
	shirt, because he "I days" because "the she re-approached so. NA-C stated R3 [10/22/13]" and exp assistance with gro assigned to care fo - From 7:00 a.m. th remained up in the between the TV are the hallways of the	ikes to wear them for several y're not dirty." NA-C stated R39 and would continue to do 9 had a shower "yesterday olained R39 required oming. NA-C verified she was r R39 that morning. rough 7:45 p.m. R39 wheelchair and moved ea, the small dining room and unit.		* The date of completi will be 12-4-13.	on	
	dining room and re- and the breakfast n - At 8:48 a.m. R39 the dining room and shower room and to independently at 8: - At 9:02 a.m. LPN- room door and ask room, R39 respond and NA-A entered a immediately wheele - At 9:10 a.m. R39 and watched TV qu	wheeled himself slowly out of d down the hallway to the ransferred himself to the toilet				
	9:19 a.m. When as R39 laughed and s - At approximately was aware of R39 l she did not offer to	ked if he had nail care offered, hook his head no. 9:40 a.m. NA-C explained she naving long nails and stated cut them. NA-C explained she offer to cut fingernails during	1	Facility ID: 00872 If contin	uation sheet P	

If continuation sheet Page 29 of 57

		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>			OMB NO	1 APPROVED 0. 0938-0391
ATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) ´cor	TE SURVEY MPLETED
		245293	B. WING)/25/13 per /24/2013
AME OF F	PROVIDER OR SUPPLIER	240200	S	TREET ADDRESS, CITY, STATE, ZIP COD		
	I LIVINGCENTER - HO	OPKINS		25 SECOND AVENUE SOUTH OPKINS, MN 55343		
(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 SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	ae 29	F 311			
	the morning cares.	NA-C stated she was unclear				10 - 10 67
	when nail care sho	uld be offered and referred the				- da e
	surveyor to speak	with the nurse. NA-C verified on 10/22/12, but was unclear if				
	nail care was offere	ed.				· · · · ·
	- At approximately	9:50 a.m. the LPN-C stated he				
	was not notified of	a refusal for nail care for R39.				4.7543
	LPN-C stated nall (care for non-diabetic residents as needed. LPN-C explained				
:	diabetic residents	had their nails cut by nursing				
	staff only, LPN-C v	erified R39's nails were long,				
	soiled and required	d trimming. LPN-C asked R39 if				
	he could cut his na	10:00 a.m. LPN-B stated nail				
	care was offered w	veekly on shower day. LPN-B				1
	reviewed the show	ver list and verified R39 had a				1
	shower on 10/22/1	3, but stated R39 could have				· · · · • • • • • •
	refused the nail ca	N-B observed LPN-C beginning				de la Casta
	to cut R39's nails i	in the resident's room. LPN-B				
	verified the nails w	vere long and stated they were				e e e e e e e e e e e e e e e e e e e
	"thick and jagged.	" LPN-C verified he worked on				
•	10/22/13, stated R	39 had refused his nail care I not report the refusal to				- 58 - 261 Be
	LPNM-B or offer to	o assist with nail cares.				
	- At 11:11 a.m. LP	N-B verified the documentation				
	on the Compreher	nsive Skin Assessment was				
	where R39's nall of	care refusal should have been I-B verified the documentation				
	indicated R39's na	ail care was not completed				
	since 8/15/13. LPI	N-B stated although nail care				
	may be offered by	the NA or nurse, it may not				· · ·
	have been docum	ented and should have been. hen asked regarding the				
	- At 12:09 p.m. Wi	Isals of care, NA-C stated if a				
	resident refused of	cares, staff were instructed to				
	re-approach a "litt	le bit later" and if the resident	_			
	continued to refus	se a care, to report the refusal to	ס			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 11/13/2013 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		245293	B. WING			0/25/13 per (/ 24/2013 -
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, ST		24/2013
GOLDEN	LDEN LIVINGCENTER - HOPKINS			725 SECOND AVENUE SO HOPKINS, MN 55343	UTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 311	The Admission Rec R39's diagnoses in and dementia witho The quarterly Minim 7/17/13, indicated F Mental Status (BIM cognitive losses) so to severe cognitive limited assistance v MDS indicated R39 problems. The Car dated 10/15/13 and activities of daily liv The Order Review diagnoses and dire comprehensive ski cares on bath day.' started on 7/2/13, a 9/11/13. The Comprehensiv 10/22/13, indicated during his shower. "Yes/No" to circle if completed. The for lacked documentat after. LPN-B pointe explained R39's na had "refused." Wh staff offering to cut other than shower of should have offered times" and if R39 ro LPN-B stated if R31 have notified him. I attempt to cut the r A blue binder labele	cord dated 6/1/13, indicated cluded Alzheimer's disease out behavioral disturbance. hum Data Set (MDS) dated R39 had a Brief Interview of S, a tool used to determine core of 7 (indicating moderate impairment) and R39 required with personal hygiene. The b had no mood or behavior e Area Assessments (CAAs) d 10/24/13, indicated the ing (ADL) CAA did not trigger. Report reviewed R39's cted, "Complete n assessment & diabetic nail ' The order was dated as and signed by the physician on re Skin Assessment form dated R39's skin was assessed The assessment included a 'R39's nail care was m was checked "no" and ion why in the space provided ed to the previous week and ils were not cut then and R39 en asked regarding nursing R39's fingernails on days days, LPN-B verified staff d nail care "at least three efused, notify the nurse. 9 still refused, staff should _PN-B stated he would then	F3			
	assignment sheets	(used to direct individual s). The sheet identified R39	11	Facility ID: 00872	If continuation shee	at Page 31 of 57

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245293	(PLE CONSTRUCTION G	COM	e survey ^{APLETED})/25/13 per
NAME OF PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 725 SECOND AVENUE SOUTH	=	
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	HOPKINS, MN 55343 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
guard at all times transfers, indeper walker, was conti- bladder and requi- special instruction "Alert X2 [time tw Grooming, & Dre- refuses." R39's care plan fr 10/28/11, identified deficit. The care p & PRN [as needed On 10/24/13, at 2 (DON) stated her residents well gro- residents well gro- residents well gro- residents were re- mental illnesses. better job" docum nail care was not staff re-approach The facility lacke care, including fr staff responsible associated with r anticoagulant us- R56 was observed during the evenir subsequent days 10/23/13, the res and soiled. On 10/21/13, at observation R56 dining room com- around him was	ver dentures, used a wander was independent with adent with ambulation with a nent of bowel, incontinent of red a "Toileting Plan." The is section of the sheet directed, o]. Assist w/ [with] Bathing, ssing, Reapproach [sic], if he or self-care deficit dated ed R39's risks associated with olan directed, "Nail care weekly ed]." 2:11 p.m. the director of nursing expectation was to have all bomed. DON stated "a lot" of esistive with cares and had other DON stated staff should "do a nenting in the space provided; if provided, was refused and if red the resident. d a policy regarding resident nail equency of resident nail care, for nail care and risks nail care, such as diabetes or	5			

TATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DA COI	0. 0938-0391 TE SURVEY MPLETED
		245293	B. WING)/25/13 per /24/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOLDEN	I LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	ge 32	F 3	11		4 6 <u>6</u> 96 64
	observed nails wer both hands and un	a.m. resident nails were e still long and untrimmed to shaven face resident was lying as not feeling good and was				
	-At 7:42 a.m. NA-A resident room and was sitting at the e room. -At 7:44 a.m. NA-A to assist finish resi -At 7:45 to 7:47 a.r	g continuous observation: was observed returning to shut the door. At that time R56 dge of the bed. NA-A left the came back to room with NA-B dent cares. n. NA-A left the room to get a she needed it to use to wash				
	resident's bottom v -At 7:48 to 7:50 a.r observed attemptin was unsteady then the edge of the be "just lay me down this is always easy assisting R56 with	when he stands up. n. both NA-A and NA-B ng to stand R56 who stated he sat him down immediately at d. After sitting R56 told NA-A and change me and wash up for me." NA-B was observed his feet to bed.				
	R56 with pericare side to side during the dignity product was turning to the NA-B reached ove stated I will not let be long and soiled	m. NA-A observed assisting and was giving him cues to turn cares, applying and to fasten . During that time when R56 left R56 stated "Woo" and r and held R56's right hand any you fall. Nails still observed to approximately 1/2 inch long	d			
	neither NA-A nor N -At 7:55 a.m. obse R56 to stand and During transfer NA side as NA-B lead	NA-B offered to trim R56's nails rved NA-A and NA-B assist with a transfer belt and walker. A-A cued R56 to turn to his righ R56 arm and walker to the st until R56 sat down on his		Facility ID: 00872	f continuation she	

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	CON	¹ PLETED 1 /25/13 per
		245293	B. WING _		- 10	24/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 725 SECOND AVENUE SOUTH	ODE	
OLDEN	I LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	ae 33	F 31	11		
1 011	-At 7:57 a.m. obser	ved R56 sitting on his				
	wheelchair and still soiled nails to both	was unshaven and with long hands in his room.				
	-At 8:13 a.m. obser	ved NA-B wheeling R56 past to the dining room and R56				
	was shaven but stil	I had long soiled nails.				
	room independent	n. observed R56 in the dining yeating talking to other				
	residents around th	he table. R56 stated the aide Ind thought she had done a				
	good job for now.					
	10/23/13, at 9:42 a	.m. during a random				
	resident on his who	his room visiting with another eelchair, observed still to have				
	long and soiled nat	ls. R56 stated staff usually lipping his nails and he verified	1			
	the nails needed to	be clipped.				
	The care plan date	d 7/14/13, identified resident				
	related to rhabdom	ioning and self-care deficit yolysis, glaucoma, congestive				· · · · · · · · · · · · · · · · · · ·
	heart failure and c	ardiomyopathy. Goal "will be med and free of odor." The				
	nursing assistant a	assignment sheet "Team				
	bathing, grooming	esident required assist with , and dressing. The "2E South				
	Shower Schedule'	directed R56 to receive a ening shift (PM) on Monday.				
	R56's 60-day MDS	S dated 9/11/13, identified R56				
ti a a	personal hygiene	ysical assist of one staff with needs. The Comprehensive				
	R56 required assis	mary dated 7/27/13, indicated st of one with bed mobility,				
	transfers, dressing	, toileting, bathing and hygiene).			
	Review of the July	through October 2013 kin Assessment indicated R56	an - Canada - Makeron			
	had nail care com	pleted 10/7/13, and 7/30/13. In				

		& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1	IG	COMPLETED 10/25/13 per
		245293	B. WING		10/24/2013
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH	$E_{\rm eff} = E_{\rm eff}$
GOLDEN	I LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 311	Continued From pa	age 34	F 3	11	
1 011	addition nail care h times with no rease completed on 7/23	ad been circled "No" four on as to why nail care was not /13, 10/21/13, 10/14/13and /as circle of the two options on			4 57 • • •
	expectation was all done per care plan residents to get qui expected the nursi sure resident call- at reach before lea also need to make addition LPN-C sta the day not shave	36 a.m. LPN-C stated his Il resident cares were to be and he expected all the faility care. He further stated he ing assistants to always make light and all personal items are aving the room and the aides a sure the resident is safe. In ated if he saw a resident during n or needing grooming he nursing assistants to make sure a end of his shift.			
	had completed pr	54 a.m. NA-A further stated sho oviding resident with morning heck later and toilet him.	Ð		
	nails were long ar little long and nee was done on the needed to check see the nails were he remembers sta and then stated "l	:14 a.m. LPN-C verified the nd soiled and stated "they are a d to be clipped" stated nail care resident bath day but aides and do it daily as soon as they e long. Additionally R56 stated aff cutting his nails in the past I like to them long to pick my ed at surveyor and nurse with a "Am joking."	•		
	care was done we residents and if a nails long then we	2:50 p.m. LPN-B stated nail eekly with the bath for all the resident preferred to keep thei ould honor their wish. LPN-B to keep long nails was not care		Facility ID: 00872	inuation sheet Page 35 of 57

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	0938-0391 SURVEY LETED 25/13 per
		245293	B. WING		-10/2	4/2013
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OLDEN	LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
			_	PROVIDER'S PLAN OF CORRECTIC	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
F 311	Continued From pa	ige 35	F 311			n příz
	planned. He also ve	erified R56's nail care was				
	circled "NO" on 10/	14/13 and 10/21/13, and there tion as to why nail care was				
	not completed. LPN	N-B further stated he expected				
	staff to assist resid	ent with grooming according to				
	the plan of care.					
	On 10/24/13, at 2:1	1 p.m. the DON stated her				4 D
	expectation was to	have all residents well ted "a lot" of residents were				
	resistive with cares	and had other mental				5-1 1-5
	illnesses at the uni	t. DON stated staff should "do				
	a better job" docun	nenting in the space provided; provided, was refused and if				
	staff re-approache	d the resident.				
1 1	$O_{2} = 10/25/13$ at 8:0	01 a.m. registered nurse				
	(RN)-A stated nail	care would not be on the				ante de su
	treatment administ	ration record (TAR) unless a				
	nurse was required gets done. RN-A c	d to do it, it just automatically ould not understand how nail				e e e
an tr	cares would fall of	f from PCC; "You only change				
		o transfer and I do not 56 nail care was not continued				i sana
	in 2 East."					
		0.4 - m the DON stated their				
		34 a.m. the DON stated their ning only included diabetics, it				
	would be on the T/	AR for the licensed nurses to				
	do and the policy of Coumadin.	did not include residents on				· . ·
	On 10/25/13, at 10	:00 a.m. the DON verified				
	trimming of nail ca	re was on the September TAR ned off once on 9/13/13, but				
	was not on the TA	R after resident transferred				
	units. DON stated say 2 East on the	"I didn't know why that would				

If continuation sheet Page 36 of 57

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY
		245293	B. WING			1)/25/13 per (/24/2013 -
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COL	DE	
GOLDEN	LIVINGCENTER - HO	OPKINS			ND AVENUE SOUTH S, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR EACH CORRECTIVE ACTION S OSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 211	Continued From pa	age 36	F	311			
	The facility lacked care, including free staff responsible for	a policy regarding resident nail quency of resident nail care, or nail care and risks	-				n de la Solard La Solard La Solard La Solard
	associated with na anticoagulant use.	il care, such as diabetes or					
	Ambulation: R56 was not ambu therapy after he wa	llated as directed by physical as discharged from therapy.					
	was noted: - At 7:55 a.m. NA-	was observed and the following A and NA-B were observed to					
	During transfer NA	vith a transfer belt and walker. A-A cued R56 to turn to his right ed R56's arm to the wheelchair ansfer R56 stood, had short,					
	shuffling steps and then sat down in t -At 8:13 a.m. NA-	d walked approximately 5 feet he wheelchair. 3 was observed propelling R56					and the second sec
	dining room. - At 2:10 p.m. NA-	Past the nursing station to the A stated she ambulated R56 from to the dining room before					
÷ у [†]	lunch but had not meal.	ambulated R56 back from the					
	extensive physica toileting and trans	9/18/13, indicated R56 required assist of one with bed mobility fers. In addition, the MDS did	, ,				-
	not have informat transition from sit room or corridor.	ion on the resident's ability to to stand, walk/ambulate in the					
	physical functioni to rhabdomyolysi anemia, hyperten	ted 7/14/13, identified R56 with ng and self-care deficit related s, atrial fibrillation, glaucoma, sion, congestive heart failure thy as evidenced by needing					

TEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
PLAN U	FCORRECTION)/25/13 per
		245293	B. WING			24/2013
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
	UNUNCOENTED H	DRINS		725 SECOND AVENUE SOUTH		
OLDEN	LIVINGCENTER - HO			HOPKINS, MN 55343		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 37	F3	311		. 0.57
1 011	assist with ambula	tion, bed mobility, repositioning on. Care plan goal "will continue ssist up to 50 feet." The care				
	plan also directed and walker to amb	assist of one with transfer belt ulate and nurse to complete				
Д.	participation, dista assistant assignm directed the nursin	progress notes on nce and pain. The nursing ent sheet "Team 1 (Alpha)" ng assistant to ambulate				
过 1月1 1月1	resident with assis walker.	it of one with transfer belt and				i i i i i i i i i i i i i i i i i i i
	received physical 9/17/13. The PT [] Progress & Disch	review it was revealed R56 had therapy from 7/13/13 to ohysical therapy] -Therapist arge Summary dated 9/17/13,				
	indicated R56 was progress. Summa made significant r	s discharged due to plateau in iry further indicated R56 had progress overall including his				a an An An
	50% cues compa	with stand by assist of one with red to maximum assist of two in on. The PT -Therapist Progress mary also indicated "Pt [Patient				
	is on ambulation and from meals to	orogram with nursing staff to o maintain ability to ambulate'				
	MDS was R56's a time R56 was bei	:06 p.m. RN-B stated 7/19/13, admission MDS and during this ng treated for vascular wounds.				
	antibiotic for cellu addition, R56 was	R56 was being treated with an litis which had been changed. Ir s complaining of back pain and ore assistance especially with	1			
01 - 1 1919 -	bed mobility. But improved as R56 extensive on the	overall R56's ADLs had required limited assist from previous MDS. RN-B further				
	stated R56 rema transfer on both	ined extensive assist of one with MDS and R56 had been therapy on 9/17/13.	1			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 11/13/2013 APPROVED D: 0938-0391	_
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION) co	te survey MPLETED 0/25/13 per	r GD
		245293	B. WING		-10	/24/2013	
NAME OF F	PROVIDER OR SUPPLIER	L	1	STREET ADDRESS, CITY, STATE,	ZIP CODE]
GOLDEN	I LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	1	Ţ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE	_
F 311	Continued From pa	age 38	F3	311			
	stated at the start F of two with parallel stairs and maximu physical therapist v issues with pain to beginning of therap time. The physical discharge R56 was stand by assist and therapist also state the ulcers in the to physical therapist R56 had been prov (Darco shoe) for h and transfer abilitie and through disch- biggest barrier for On discharge from had gave nursing continue ambulatin physical therapist resident was disch recommendation i not responsible ar concern arises.	10 a.m. the physical therapist R56 required maximum assist bars and was not able to do m assist with bed mobility. The went on to state R56 had both posterior ankles at the by but had gotten better over therapist went on to state at a walking 150 to 300 feet with d with walker. The physical ed the pain was more related to es which were addressed. The further stated during therapy vided an open toed shoe is right foot and his ambulation es had improved greatly during arge from the program but the resident was cognitive issues. In therapy The physical therapist a communication sheet to ng R56 to and from meals. The finally stated that once a harged from therapy and s made to nursing therapy was ad would not follow up unless	t				
	was a communica needed to be amb made upon discha was transferred fr went on to state th he had noted on t assignment sheet 10/1813, LPN-B h feet to see his abi	2:40 p.m. LPN-B stated there ition breakdown that R56 pulated per recommendation arge from therapy, when R56 om 1 West to 2 East. LPN-B nat when R56 transferred to uni he 2 East nursing assistant s R56 was ambulating and on ad ambulated the resident 100 lity. Additionally LPN-B verified umentation of R56 ambulating	1 1 1				
	2567(02-99) Previous Versio	ns Obsolete Event ID: EKK	711	Facility ID: 00872	If continuation she	eet Page 39 of 5	57

		AND HUMAN SERVICES			FORM OMB NO): 11/13/2013 1APPROVED 9. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	CON	re survey MPLETED 1/25/13 per 0
		245293	B. WING _			124/2013
NAME OF	PROVIDER OR SUPPLIER		- <u>I</u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOLDEN	N LIVINGCENTER - H	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 39	F 3	11		and the second sec
1 011	from 9/17/13 until would take respon- ambulation program implemented upon	10/18/13. LPN-B stated he sibility for not ensuring the m recommended by PT was transfer to 2 East on 9/26/13.				
	was not sure abou therapy and nursin therapy as she had was not able to pro recommendation of	communication note when				
	further stated that nurse in charge of	harged from therapy. She staff including the registered the unit where resident had not sure if that had been them either.				
	Unit (TCU)/1 Wes	25 a.m. the Transitional Care t manager RN-A stated R56 ransfer on admission to TCU,				1
	changed to assist knew he was walk remember if he w	f his stay in TCU he had of 1 with transfer. She stated " king with PT but I could not as walking with nursing. RN-A omeone were ambulating, it	I			
	would be on the te therapy was comp supposed to be an TAR." RN-A furthe	eam sheet; normally if physical bleted and resident was mbulated it would be put on the er stated she did not have a sheet from when R56 was at				
	TCU to look back problem as R56 r to being moved to -At 7:35 a.m. NA-	if R56 had been on a walking emained in TCU for 9 days pric o 2 East. D remembered R56 from room				
	cared for him. "I v brush his teeth, g with the EZ stand	an EZ stand lift when she last vould set him up so he could et his pants on and then lift him to wash the peri-area. Æ stated R56 transferred with	ו			

		AND HUMAN SERVICES				PPROVED
STATEMENT	RS FOR MEDICARE	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		SURVEY LETED
		245293	B. WING			25/13 per (4/2013
	PROVIDER OR SUPPLIER	DPKINS		STREET ADDRESS, CITY, STA 725 SECOND AVENUE SOL HOPKINS, MN 55343	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 311	mechanical stand, eating. Did not amb ambulate. Team sh able to ask for help -At 7:45 a.m. LPN-I wound care on his abdomen/hip area, with therapy to the -At 7:50 a.m. reque and evaluate his ar -At 7:55 a.m. RN-C giving R56 pills and changes and never On 10/25/13, at 8:0 "Usually when a re- unit, social service nurse moved the m reported to the floo (CM) reported to the receiving unit to rel information." RN-A transfer and believe LPN-B. RN-A furthe Click Care (PCC) h was needed and ba sheet was reported	he was independent with bulate with R56 or see him leet said assist of one; he was D remembered R56 needed left leg, right lower leg and left and he had seen R56 walking nursing station. ested PT to ambulate with R56 mbulation ability. E stated she remembered d wound cares/dressing r saw him ambulate. Of a.m. RN-A again stated sident transferred to another moved the belongings, the hedications, the chart and or nurse. The clinical manager he clinical manager of the lay the team sheet .vaguely remembered R56's ed she gave a verbal report to er stated she used the Point Cardex to report if assistance asically everything on the team d. RN-A went on to state "If the would leave it (the PCC	FS	311		
14 13	observed apply the stand, when R56 s physical therapist a legs. R56 then star therapist holding th R56 took one rest nursing station but	10 a.m. the physical therapist e transfer belt, cued R56 to tood he reported pain to the and the pain was to both his ted walking with the physical he transfer belt at the back. break by the fire door at the walked all the way to the R56 was safely seated in the				

		AND HUMAN SERVICES				FORM	11/13/2013 APPROVED 0938-0391
STATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCT		(X3) DATE COM	E SURVEY PLETED 25/13 per (
		245293	B. WING			10/3	24/2013
	PROVIDER OR SUPPLIER	OPKINS			SS, CITY, STATE, ZIP COI VENUE SOUTH N 55343	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PRO IX (EACH	DVIDER'S PLAN OF CORR I CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 311	distance walked as distance and stated physical therapist f was about normal	age 41 ysical therapist estimated the 150 feet, then walked off the d closer to 140 feet. The urther stated the ambulation for him, "it always took him , and he used to take 2-4 rest	F	311			
	breaks." The physi feel there was a de On 10/25/13, at 8: provided to R56 ind one with transfer b	cal therapist stated she did not ecline in ambulation. 18 a.m. LPN-B stated cares cluded transfers with assist of elt, working on wounds	I.				
	(vascular ulcers or digit), and underly was to get him bac did remember gett LPN-B pulled up a R56 which indicate	n left leg and right foot 2nd ing osteomyelitis. "The goal ok to assisted living." LPN-B ing a verbal report from RN-A. nd printed the PCC Kardex for ed ambulation with assist of d he had not updated the PCC					
	therapy (DPT) stat were written onto a transferring care to been discharged f specifically for R50 record of the record have been shredd	00 a.m. the director of physica ted therapy recommendation a blue or yellow sheet when o nursing after any resident ha rom therapy. DPT stated 6 there was no copy in the mmendations as the copy may ed when he transferred to 2	d				
	East by the physic and thins out the b recommendation of was no longer in T R56 discharged b home" DPT furthe used when there a new technique is would train the sta	cal therapy aide that comes in book (three ring binder of given, or in progress) since he CU, "She must have thought ecause we did expect him to g er stated the blue sheets are are extensive issues, or when a being used, so that therapy aff and get a signature from the The yellow sheet (Maintenance	a				

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		FE SURVEY MPLETED
		245293	B. WING)/25/13 per /24/2013 -
	PROVIDER OR SUPPLIER	245255		STREET ADDRESS, CITY, STATE, ZIP C		12412010
	N LIVINGCENTER - H	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343		- -
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ARAGA DEFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
F 311	issues and was pro does not have a pl the sheet should p stated therapy sho	m) was used more for gait obably what was used for R56, ace for a signature but thought robably have that. DPT also uld probably keep a copy	F	311		
	recommendation s "In my five years w error would have r to provide a transfe physical therapist had written one an reviewed the PT d verified on dischar	ad of shredding the heets. DPT finished by stating rorking at the here, human esulted in someone forgetting er sheet, but in this case had stated that she definitely d gave it to nursing." DPT ischarge progress note and ge the physical therapist had 6 to be ambulate to and from				
	stated when she c sheet she would p	25 a.m. the physical therapist ompleted a communication ut it in the CM mailbox or hand hallway in passing.				12
i	therapist will usua 'm not here it goes right across from she then uses it to needed and place (3-ring binder) at t transfers to anoth the chart. RN-A cl	28 a.m. RN-A stated "The Ily give it to me (in person) or if I is to my mailbox in the mailroom my office." RN-A further stated o update the team sheets if is it in the communication the desk and when the resident er unit she puts it at the front of arified there was not place at leave the document.	1			
	On 10/25/13, at 9 usual process for the therapist fills of directly to the nur- follows up and se	34 a.m. the DON stated "The therapy to nursing transfer is but a form and generally gives it se manager. And the manager ts it up appropriately." She a resident was ambulating to	711	Facility ID: 00872	continuation she	

ENTERS FOR MEDICARE & I	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	_ CON	re survey MPLETED 1/25/13 per (
	245293	B. WING			24/2013
ME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S ² 725 SECOND AVENUE SC		
DLDEN LIVINGCENTER - HOPK			HOPKINS, MN 55343		
(EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
nurse needs to sign of just go to the team she range of motion it wou ambulating in the corri the care plan and team plan for R56 failed to i ambulation program a	t to be on the TAR, and the f but in some cases it may eet." She added "If it was Id go to the TAR. If dor I would anticipate it on n sheet." The DON the care dentify R56 was on an s per therapy	F 3	11		
would expect to see th team sheet filled out w per therapy recommen LPN-B had not written recommended by ther stated a transfer from unit would include soc one of the transfer and belongings. The nurse and chart up and give	/ith matching information ndation. She also verified				
2013, lacked informat assessing, re-assess resident(s) progress v program and lacked t recommendations up continue with ambula F 329 483.25(I) DRUG REG	ng and tracking of vhen on a ambulation racking of therapy on discharge for nursing to tion to maintain abilities. IMEN IS FREE FROM	F 3	29 F 329		12-4-13
SS=D UNNECESSARY DRI Each resident's drug unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mod	JGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of		R162 have ap diagnoses fro for the use o psychotropic Resident R214	m the physician f their medications. has the arget behavior	
RM CMS-2567(02-99) Previous Versions Ol	Disolete Event ID: EKK7	'11	Facility ID: 00872	If continuation she	et Page 44 of 57

		AND HUMAN SERVICES			0		APPROVED 0938-0391
TEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	Сом	e survey pleted 25/13 pei
		245293	B. WING				24/2013
			1		EET ADDRESS, CITY, STATE, ZIP CODE	1 101	
ME OF F	PROVIDER OR SUPPLIER				SECOND AVENUE SOUTH		
LDEN	LIVINGCENTER - H	OPKINS			PKINS, MN 55343		
(4) ID REFIX 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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
					determine the efficacy of	the	
- 329	Continued From pa	age 44	F 3	329	antipsychotic medication.		
		nces which indicate the dose			* All residents receivir	ng	
	should be reduced	or discontinued; or any			psychotropic medications	will	
	combinations of th	e reasons above.			have the appropriate	i.	
					diagnosis in place for the	ne	
	Based on a compr	ehensive assessment of a			use of the medication. A	11	
	resident, the facilit	y must ensure that residents			residents receiving		
	who have not used	antipsychotic drugs are not			antipsychotic medications		l 1 de Rom
	aiven these drugs	unless antipsychotic drug			will have the appropriate	Э	a na con A Col
	therapy is necessa	ary to treat a specific condition			target behaviors in place	e to	
	as diagnosed and	documented in the clinical			evaluate the efficacy of	the	
÷ f	record: and reside	nts who use antipsychotic			medication.		19 - N
	drugs receive grad	dual dose reductions, and			* The Clinical Managers		
	behavioral interve	ntions, unless clinically			the Licensed Social Work		
	contraindicated, in	an effort to discontinue these			have been educated on the		· · · · ·
	drugs.				requirement to obtain fr the physician the approp	riate	
	-				diagnosis for the use of	Llace	
					psychotropic medications	and	
	1.				the requirement to put i	n	
					place target behavior		
					monitoring for all resid	ents	
	This REQUIREME	ENT is not met as evidenced			receiving antipsychotic		
	by:	a set to the summer of the second second			medications.		1
	Based on observ	ation, interview and document			* Monitoring to ensure		
	review, the facility	failed ensure psychotropic			compliance will be condu		
	medications had a	appropriate physician's			through random chart aud		
	justification for us	e for 2 of 5 residents (R214,			of residents receiving		
	R162) reviewed to	or unnecessary mediations. In			psychotropic medications	to	
	addition, the facili	ty failed to ensure 1 of 5 had target behavior monitoring			ensure the appropriate		
	residents (K214)	efficacy of the Seroquel (an			diagnosis for use is in		
	antipsychotic med	dication)			place. Random chart aud		
	anupsycholic med				will also be conducted f	or	
	Findings include:				residents receiving		
•	Findings include:				antipsychotic medication		
5 g. G 1	R211 was observ	ed on 10/22/13, at 10:45 a.m.			ensure appropriate targe		
	sitting in a wheel	chair actively participating in a			behavior monitoring is i		
	social activity pro				place.		1.
	Social activity pro	gram			* The facility QAPI		
	D	vealed a Clinical Pharmacist			committee will review th	19	

Event ID: EKK711

Facility ID: 00872

If continuation sheet Page 45 of 57

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245293	B. WING				/25/13 per 24/2013
IAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - H	OPKINS			PKINS, MN 55343		an an San San San San San San San San San San
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Letter to Physician one day after adm "Please consider of mg po [by mouth] discontinuation", s 8/23/13, indicating and on 8/26/13, th	a Services, dated 8/20/13 (only ission), with recommendation dose reduction to Seroquel 12.5 with the goal of igned by the physician on recommendation accepted, the Seroquel dose was reduced	F	329	results of the audits for psychotropic medication diagnoses and antipsycho- target behavior monitori quarterly for further recommendations. * The date of completic will be 12-4-13.	tic .ng	
	and on 8/26/13, the Seroquel dose was reduced to 12.5 mg po BID. The facility staff did not identify appropriate diagnoses for R214's psychotropic medication. On 8/30/13 (only four days after dose reduction) staff contacted the physician via written communication form requesting the Seroquel to be increased since R214 was aggressive with staff, and "last night resident was yelling, hitting bit staffs finger". The Seroquel was increased to 25 mg po twice daily.						
	8/30/13, noted R2 as delirium, hallu altered level of co behaviors such a symptoms directe noted with diagon	inimum Data Set (MDS) dated 214 have not any behaviors such cinations, disorganized thinking, onsciousness, or any other s verbal, physical behavioral ed towards others. The MDS osis including Alzheimer's uentia without behavioral					
	dated 8/30/13, in behaviors r/t [due medication to ma	are Area Assessment (CAA) dicated "resident displays e to] Alzheimer's and receives anage and treat condition." The cate what kind of behaviors R214	ŀ				
4	indicated: "SERC	lectronic Physician's Orders Dguel tablet Give 25 mg buth two times a day [BID] for					

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	e survey IPLETED /25/13 per
		245293	B. WING _		-10/	24/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 725 SECOND AVENUE SOUTH	DE	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	HOPKINS, MN 55343 PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	329 Continued From page 46 ANTIPSYCHOTIC'' with 8/30/13, start date.		F 3:	29		
	and 9/30/13, indica Adjustment Disorc	Progress Notes dated 9/3/13, ated R214 had Alzheimer's and ler with Anxiety, however did ses for Seroquel use.				
	Summary revealed reviewed R214's r 10/16/13. The phat appropriate physic the Seroquel use	dication Regimen Review d the consultant pharmacist nedications on 9/17/13, and armacist did not identify the lack cian indication/ diagnoses for and the lack of target behavior otember 2013 or October 2013.				
	The care plan lac	dated 9/19/13, was reviewed. ked indication of the Seroquel ere no non-pharmacological tified.				ક મોચ
	9/12/13 and 8/23	ogress Notes dated 10/4/13, /13, were reviewed, noted R214 nspecified, without behavioral				
	identified three ta anger, 2. believe him down stairs, were no target be	or observation for August 2013 arget behaviors: 1. persistent s family/ people are waiting for 3. verbal aggression. There ehaviors monitored for or October 2013.				
	was interviewed The RN-C review there were no ph diagnoses for the planning of the c	urse (RN)-C/clinical manager on 10/24/13, at around 1:10 p.m ved R214's record and confirmen hysician justification/appropriate e Seroquel use, the lack of care hysychotropic medication and the lack of target behavior	d			

STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DAT CON	. 0938-0391 E SURVEY IPLETED /25/13 per G
		245293	B. WING _			24/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 725 SECOND AVENUE SOUTH	CODE	
GOLDEN	LIVINGCENTER - HO	JPKINS		HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa monitoring for Sep	age 47 tember and October.	F 32	29		
	10/25/13, at 9:30 a be physician docur indication identified medication use. Th the facility's expec irregularities such diagnoses, lack of	sing (DON) was interviewed on .m. and explained there had to mented diagnoses/clinical d to justify the psychotropic me DON also explained it was tation the pharmacist to identify as: lack of appropriate target behavior monitoring, ate recommendations.				
	revised 2013, note not be used unles one or more of the as dictated and do The policy listed 1 "Organic mental s dementia, and am disorders by DSM and/ or agitated b noted "Each resid from unnecessary any drug when us excessive duratio without adequate presence of adve indicates the dose	agement Guideline policy ed "Antipsychotic drugs should is the clinical record documents e following 'specific conditions', ocumented by the Physician." 1 diagnoses, including 11. yndromes (now called delirium, inesic and other cognitive -IV) with associated psychotic ehaviors". The policy also ent's drug regimen will be free r drugs. An unnecessary drug is ed: in excessive dose, for n, without adequate monitoring indication for it's use, in the rse consequences which e should be reduced or combination of the above				
	returning from the	ed on 10/21/13, at 3:58 p.m. e lobby with a cup of coffee. Or a.m. R162 was returning from hysical therapy.	1			
	The admission M	DS dated 10/7/13, noted				

DEPART		AND HUMAN SERVICES			RINTED: 11/13/2013 FORM APPROVED //B NO. 0938-0391
ATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/25/13 per (
		245293	B. WING		-10/24/2013 -
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE SOUTH	
GOLDEN	LIVINGCENTER - H	IOPKINS		PKINS, MN 55343	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	without behaviora disorder, Parkinso therapies. R162's Status (BIMS) sco intact cognitive sta behaviors such as disorganized think such as verbal or towards others. R162's current Ph indicated: "Depak anti-seizure medi bipolar disorder) problem; Trazodo medication) 50 m or staying asleep antipsychotic me schizophrenia or bedtime for diffic The Clinical Phan Services dated 1 not indicated for actually has a bla Alzheimer's patie	sis of psychosis, dementia I disturbances, delusional on's disease, and need for reha Brief Interview for Mental ore was 15 which indicated atus and did not indicate any s delirium, hallucinations, king, or any other behaviors physical symptoms directed hysician's Orders dated 10/7/13 kote extended release (an ication that can be used for 500 mg every day for memory one (a sedating antidepressant ng at bedtime for difficulty falling o as needed; and Zyprexa (an dication that can be used for bipolar disorder) 5 mg at ult falling or staying asleep. rmacist Letter to Physician 0/8/13, indicated Zyprexa was the treatment of sleep and ack box warning for the use in ents due to increased risk of			
	review the diagn If none of the ab for Zyprexa) app reduction to Zyp for 2 weeks, the physician selecter supporting docu	tter recommended " Please osis for use of this antipsychotio ove (list of appropriate diagnos oly. Please consider a dose rexa 2.5 mg by mouth at bedtim n discontinue." On 10/9/13, the ed rejected but did not provide mentation. The Pharmacist did of appropriate diagnosis for	ne		
- Via	The admission (CAA dated 10/16/13, did not			uation sheet Page 49 of 5

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245293		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/25/13 per 10/24/2013
	ROVIDER OR SUPPLIER	243233		STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/24/2010
	LIVINGCENTER - H	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 329	but did indicate psy behaviors in the hi	um or cognitive loss/dementia, ychotropic drug use for story and physical CAAs lacked evidence of any	F 329	3	
	were reviewed and versus Alzheimer's indicate any behav lacked evidence o psychiatric notes v	gress Notes dated 10/29/13, d indicated dementia vascular s on Depakote, but did not viors. The medical record f additional progress notes or which would indicate an osis for Depakote and an tion for Zyprexa.			
- - - -	dated October 20 Depakote had bee needed had not b	edication Administration Report 13, indicated Zyprexa and en given daily, but Trazodone as een given to R162 for difficulty asleep (appropriate indication).			
	2013, identified tw 1. Paranoid stater One target behav 1. Insomnia. Ther sheets for the use were documented documented a sle	or Observation for October vo target behaviors for Zyprexa: ment 2. Delusions (psychosis). ior was identified for Trazodone: re was no behavior monitoring of Depakote. Zero behaviors d for any medication. The facility eep study for seven nights from 0/11/13, which did not provide			
	Summary revealer reviewed R162's	edication Regiment Review ed the consultant pharmacist medications on 10/7/13 and only n appropriate indication for the the Depakote.	/		
	R162's care plan	dated 10/5/13 and 10/21/13,			uation sheet Page 50 of 5

	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CO	te survey Mpleted)/25/13 per	
		245293	B. WING		Contraction of the second s	/24/2013	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343				
(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 DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Trazodone for inso received Trazodon dated 10/4/13 indic paranoid statemen use of Zyprexa to r included non-phan however no behav Zyprexa was order and stay asleep (n care plan dated 10 related complication psychotropic medi medication lacked On 10/23/13, at 10 registered nurse-o West TCU) explain requested for Zypr not an indication, a listed for Alzheime Medication Regim	indicated R162 received mnia, although R162 had not e in the facility. A care plan cated behaviors which include its, delusions, psychosis, and manage those behaviors which macological interventions, iors were recorded and the red for inability to fall asleep ot an appropriate indication). A 0/21/13, for potential for drug ons associated with cations, although the appropriate indications for use.	F 32	9			
	request a clarification the letter of recommendation of the letter of the	sultant pharmacist did not tion for indication for Depakote commendation to the physician. A:33 p.m. the consultant iterviewed regarding ications and stated Zyprexa for sleep and "I wrote the to provide appropriate clinical pharmacist further stated had written Depakote for e Medication Regimen Review d not requested a clarification o e physician.					

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	PLE CONSTRUCTION G		E SURVEY PLETED
			B. WING			25/13 per 24/2013
		245293	B. WING	STREET ADDRESS, CITY, STATE, ZIP CC		2412013
NAME OF P	PROVIDER OR SUPPLIER			725 SECOND AVENUE SOUTH		
GOLDEN	LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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) COMPLETION DATE
E 220	Continued From pr	age 51	F 32	29		
F 329	one or more of the as dictated and do The policy listed 1 [°] "Organic mental sy dementia, and am	the clinical record documents following 'specific conditions', cumented by the Physician." I diagnoses, including 11. yndromes (now called delirium, nesic and other cognitive				
	and/ or agitated be noted "Each reside from unnecessary any drug when use excessive duration	IV) with associated psychotic haviors". The policy also ent's drug regimen will be free drugs. An unnecessary drug is ed: in excessive dose, for n, without adequate monitoring, ndication for it's use, in the				
	presence of adver indicates the dose discontinued, any reasons."	se consequences which should be reduced or combination of the above				12-4-13
F 428 SS=D	483.60(c) DRUG	REGIMEN REVIEW, REPORT T ON	F4	28 F 428		15-4-12
	The drug regimen	of each resident must be once a month by a licensed		* The resident R214 documented physician indication for the u antipsychotic medica	n clinical use of the ation and	
	the attending phys	nust report any irregularities to sician, and the director of e reports must be acted upon.		has the appropriate behavior monitoring for the use of the antipsychotic medica * The facility cons pharmacist will rev	in place ation. sulting	
		ENT is not met as evidenced		resident drug regime monthly and will rep lack of appropriate indications for psyc	ens port the clinical	
	facility consulting	ew and document review, the pharmacist failed to identify and es concerning the lack of	1	medication use and report the absence behavior monitoring residents receiving	will of target for	
		ented clinical indication and the			ations to	

Facility ID: 00872

If continuation sheet Page 52 of 57

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245293	B. WING			/25/13 per 24/2013 -
AME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODI 725 SECOND AVENUE SOUTH	Ξ	
OLDEN	I LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		:
(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 CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	the efficacy of the S medication) for 1 o for unnecessary m Findings include: R214 was observe sitting in a wheel c social activity prog R214's Admission admitted to the fact including Alzheime without behavioral Further record revi Pharmacist Letter 8/20/13 (only one of recommendation " to Seroquel 12.5 m of discontinuation" 8/23/13, indicating and on 8/26/13, th to 12.5 mg po BID identify lack of app On 8/30/13 (only for staff contacted the communication for be increased since staff, and "last nig bit staffs finger". T 25 mg po twice da The admission Mit 8/30/13, noted R2 as delirium, halluce	vior monitoring to determine Seroquel (an antipsychotic f 5 residents (R214) reviewed edications. ed on 10/22/13, at 10:45 a.m. hair actively participating in a ram. Record indicated R214 was sility on 8/19/13, with diagnosis er's disease and dementia disturbances. iew revealed a Clinical to Physician Services, dated day after admission), with 'Please consider dose reduction ng po [by mouth] with the goal ', signed by the physician on recommendation accepted, e Seroquel dose was reduced . The pharmacist did not propriate diagnoses. our days after dose reduction), e physician via written rm requesting the Seroquel to e R214 was aggressive with ht resident was yelling, hitting + 'he Seroquel was increased to		the attending physicia DNS. * The consulting phas has been educated and aware of the requiremed report lack of indicat the use of antipsychol medications and the la appropriate target be monitoring for those residents receiving antipsychotic medicat the physician and the * Monitoring to ensu compliance will be co through random audits consulting pharmacist recommendation summar reports for recommend required for medicati clinical indications and recommendations f appropriate target be * The facility QAPI committee will review results of the pharma audits quarterly for f recommendations. * The date of complet 12-4-13.	rmacist is ents to tion for tic ack of havior ions to DNS. re nducted of the 's y ations on for use or haviors. the acy further	

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ND PLAN O	F CORRECTION		B. WING		10/25/13 per (
	PROVIDER OR SUPPLIER	245293	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (
	LIVINGCENTER - H	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC	N SHOULD BE COMPLETION
F 428	Continued From pa behaviors such as symptoms directed	verbal, physical behavioral	F 42	28	
	The admission Ca dated 8/30/13, ind behaviors r/t [due medication to mar	re Area Assessment (CAA) cated "resident displays to] Alzheimer's and receives age and treat condition." the te what kind of behaviors R214			
	indicated: "SERO [milligram] by mou ANTIPSYCHOTIC	onic Physician's Orders guel tablet Give 25 mg ith two times a day [BID] for " with 8/30/13, start date. Progress Notes dated 9/3/13			
	and 9/30/13, indic adjustment disorc not identify diagno	ated R214 had Alzheimer's and ler with anxiety, however, did oses for Seroquel use.			1
	Summary revealed reviewed R214's 10/16/13. The ph appropriate physic Seroquel use, an	dication Regimen Review ed the consultant pharmacist medications on 9/17/13, and armacist did not identify the lack cian indication/diagnoses for the d the lack of target behavior ptember 2013 or October 2013	Ð		
	The care plan lac	dated 9/19/13, was reviewed. ked indication of the Seroquel ere no non-pharmacological htified.			
	9/12/13, and 8/23	ogress Notes dated 10/4/13, 3/13, were reviewed, noted R21 nspecified, without behavioral	4		
	The Daily Boboy	ior observation for August 2013			

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	co	te survey mpleted D/25/13 pei	
		245293	B. WING			24/2013	
	ROVIDER OR SUPPLIER	DPKINS	STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH				
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 428	anger, 2. believes him down stairs, 3.	get behaviors: 1. persistent family/ people are waiting for verbal aggression. There aviors monitored for	F	428			
	The registered nur was interviewed or The RN-C reviewe there were no phy diagnoses for the planning of the psy (Seroquel) use, ar	se (RN)-C/clinical manager n 10/24/13, at around 1:10 p.m. d R214's record and confirmed sician justification/appropriate Seroquel use, the lack of care ychotropic medication d the lack of target behavior tember 2013 and October					
	on 10/24/13, at 1:3 reviewed R214's r and 10/16/13. The remember if she h behaviors, and wa behavior monitorii October 2013. Aft acknowledged the updated about R2	armacist (RP) was interviewed 37 p.m. and verified she have nedication regimen on 9/17/13, a RP stated she could not had reviewed R214's target as not aware there was no target of for September 2013 and er reviewing the record the RP e physician should have been 14's behaviors to write oses for the use of the	et				
	10/25/13, at 9:30 be physician docu indication identifie medication use. T the facility's expen- irregularities such diagnoses, lack c	rsing (DON) was interviewed o a.m. and explained there had to umented diagnoses/clinical ed to justify the psychotropic The DON also explained it was ctation the pharmacist to identif as: lack of appropriate f target behavior monitoring, riate recommendations.	0				

Facility ID: 00872

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 11/13/2013 FORM APPROVED IB NO: 0938-0391
TATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 10/25/13 per
		245293	B. WING		10/24/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT 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 APPROPR DEFICIENCY)	BE COMPLETION
F 428	Continued From pa		F 42	28	
	revised 2013, note not be used unless one or more of the as dictated and do The policy listed 11	agement Guideline policy d "Antipsychotic drugs should is the clinical record documents following 'specific conditions', cumented by the Physician." I diagnoses, including 11. yndromes (now called delirium,			
	dementia, and ami disorders by DSM- and/ or agitated be noted "Each reside from unnecessary	hesic and other cognitive IV) with associated psychotic haviors." The policy also ent's drug regimen will be free drugs. An unnecessary drug is ed: in excessive dose, for			
	excessive duration without adequate i presence of adver indicates the dose	a, without adequate monitoring, ndication for it's use, in the se consequences which should be reduced or combination of the above		Annual Room Size Wa	wier
F 458	483.70(d)(1)(ii) BE LEAST 80 SQ FT/	DROOMS MEASURE AT	F 4	58 F 458	<u>12-4-1</u> 3
33=E	Bedrooms must m	neasure at least 80 square feet Itiple resident bedrooms, and at feet in single resident rooms.	t	* Golden Living Center Hopkins would like to requ a waiver under F458 in regards to resident room size. The specific rooms be included in this waiver	to
	by: Based on observ	ENT is not met as evidenced ation, interview, and document		are: 140,141, 142,143,144,146,163,165,14 69,171,173,175,222,224,24 8,260,262,264,269,271, and	67,1 0,25
	review, the facility resident bedroom at least 80 square	failed to ensure 22 of 22 s met the required room size of e feet for a single resident rooms eet for a double room.	5	277. * These rooms were constructed in 1955 and d not meet the current	
	Findings include:			requirements for square footage in two-bed rooms.	
	During the entran	ce conference on 10/21/13, at		There is no method availa to increase the size of t	

Facility ID: 00872

If continuation sheet Page 56 of 57

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245293	B. WING		10/25/13	
NAME OF F	ROVIDER OR SUPPLIEF	*	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		24/2013
	LIVINGCENTER - H			725 SECOND AVENUE SOUTH HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 458	Continued From page 56 11:58 a.m. the facility administrator verified the facility had a room size waiver in place for 22 resident rooms in the facility built prior to 1955. The room numbers were: 140, 141, 142, 143, 144, 146, 163, 165, 167, 169, 171, 173, 175, 222, 224, 258, 260, 262, 264, 269, 271, and 277. The letter of waiver and the packet submitted for waiver application was provided to the survey team and included room numbers and dimensions. During the survey cares were observed in 5 of the 22 rooms and there were no concerns noted in the delivery of care. During the survey from 10/21/13, to 10/25/13, neither the residents nor the family had concerns or complaints related to the room size.		F 4	58 rooms without causin hardship on the faci * Granting this wai not adversely affect residents residing i aforementioned rooms resident's health, treatments, comfort,	lity. ver would the n the . The	γ. Ν <u>ξ</u> Κ _α ι
			treatments, comro and well-being wi maintained at the possible level. there are no conc complaints from r regarding their r * The Executive responsible for t correction and mo prevent a reoccur		will be he highest Currently ncerns or residents room size. e Director is the monitoring to	
				deficiency.		n an in the second s
· · ··						· · · · · · · · · · · · · · ·
						-
DRM CMS-25	67(02-99) Previous Version	ns Obsolete Event ID: EKK71*	1	Facility ID: 00872	continuation sheet	Page 57 of 57
						2000 2010
t						

IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245293	B. WING		10/28/2013		
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
OLDEN	LIVINGCENTER - H	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC IE APPROPRIATE DATE		
K 000	INITIAL COMMEN	TS	K 000				
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.		POCok 123-13			
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.		X1			
i. Ř	Minnesota Departr Marshal Division o of this survey, Gok found not in substa requirements for p Medicare/Medicaio 483.70(a), Life Saf edition of National (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, Fire n October 28, 2013. At the time den LivingCenter Hopkins was antial compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care Occupancies.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 5510	Division Suite 145					
Vin	wheel a	DER/SUPPLIER REPRESENTATIVE'S SIC An asterisk (*) denotes a deficiency w	terim	Elecutive Duection			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	2: 11/13/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - 2008 ADDITION				TE SURVEY MPLETED
		245293	B. WING		1	10	/28/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - HO	PKINS			OPKINS, MN 55343		
(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 SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000		@state.mn.us and	κo	00			
	FOLLOWING INFC 1. A description of v to correct the deficiency 2. The actual, or pro- 3. The name and/or responsible for corr	RMATION: vhat has been, or will be, done ency. oposed, completion date.		A REAL PROPERTY AND A REAL			
	was constructed in basement, is fully fi Type II(222) constru The facility has a fir detection in the corri corridors which is in department notifica building and the five construction type al existing health care surveyed as 1-build CMS-2786R bookle 01 in accordance w Care Occupancies with Chapter 18 Ne The facility has a car	er Hopkins Therapy building 2 2008, is one-story, has no re sprinkler protected and is of action. The alarm system with smoke ridors and spaces open to nonitored for automatic fire tion. Because the original e (5) additions meet the lowed for both new and occupancies, the facility was ing and two (2) Form the were completed; Building ith Chapter 19 Existing Health and Building 02 in accordance w Health Care Occupancies. apacity of 138 beds and had a e time of the survey.					

Facility ID: 00872

If continuation sheet Page 2 of 3

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		FOR OMB NO	D: 11/13/2013 M APPROVED D. 0938-0391 ATE SURVEY
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 · · ·		MPLETED
		245293	B. WING	10	0/28/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - HO	OPKINS		725 SECOND AVENUE SOUTH HOPKINS, MN 55343	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From pa	ae 2	K 04	6	-
	NFPA 101 LIFE SA	FETY CODE STANDARD	K 04		12-4-13
	Emergency lighting	of at least 1½ hour duration is ance with 7.9. 18.2.9.1		* The testing of the battery operated emergency light at the generator has been	
1	Based on documer with staff, the facility emergency lighting	s not met as evidenced by: ntation review and an interview y has failed to ensure that has been maintained and		<pre>completed. * The testing of the battery operated emergency light at the generator has been set up to be completed monthly for 30 seconds and annually for 90 minutes.</pre>	2 10 11 11 11 11
	7.9, 19.2.9.1. This c	e with NFPA LSC (00) Section deficient practice could affect and visitors in the event of a generator failure.		* The maintenance staff have been trained on the regulation requiring monthly and annual testing of the battery operated emergency light.	4 .
	on 10/28/13, during interview with the M	veen 12:30 PM and 3:30 PM documentation review and an laintenance Supervisor, it was		* Monitoring to ensure compliance will be conducted by the Maintenance Director or Designee through audits to	
	monthly 30 second	was no documentation of testing, and the annual 1 1/2 battery powered emergency erator.		ensure monthly and annual checks are completed. * * The facility QAPI committee will review the	
				audit results quarterly for further recommendations. * Date of completion will be 12-4-13.	

Facility ID: 00872

If continuation sheet Page 3 of 3

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		5293027	(X3) DA1	. 0938-0391 TE SURVEY MPLETED
AND FLAN U	P CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G 01 - MAIN BUILDING 01		APLETED
		245293	B. WING		10	/28/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH		
GOLDEN	LIVINGCENTER - HO	OPKINS		HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K 000			
	FIRE SAFETY		f T	J		
E14-81	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS		POC 04 18 11 29-13		10.00
Dc: /:	UPON RECEIPT C ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE		7		
-25-13	Minnesota Departn Marshal Division or of this survey, Gold found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, Fire n October 28,2013. At the time en LivingCenter Hopkins was ntial compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care Occupancies.				
EXIT: 10-25-13	PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY TAGS) TO: pections Division		NOV 2 5 2013		
	St. Paul, MN 55101			STATE FIRE MARSHAL DIVIS		
ABORATOR		PER/SUPPLIER REPRESENTATIVE'S SIG	METURE	cutie Duection	11/21	(X6) DATE
ther safegua	ards provide sufficient pro date of survey whether o	tection to the patients. (See instruction r not a plan of correction is provided. F	s.) Except for or nursing ho	tion may be excused from correcting provided or nursing homes, the findings stated above omes, the above findings and plans of correction is are cited, an approved plan of correction is	are disclosa	able 90 days closable 14

		AND HUMAN SERVIC				F	NTED: 11/13/ ORM APPRC 3 NO: 0938-	OVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA (X2) N	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			3) DATE SURVE COMPLETED	
		245293	B. WI	NG			10/28/201	3
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GOLDEN	LIVINGCENTER - HO	OPKINS		1	25 SECOND AVENUE SOUTH 10PKINS, MN 55343			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO	L PRI	D EFIX AG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		ETION
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for corr prevent a reoccurre Golden LivingCente follows: The original buildin two-stories, has no sprinkler protected construction; The 1st Addition wa has no basement, and is of Type II(22 The 2nd Addition w has no basement, and is of Type II(22 The 3rd Addition w has no basement,	 State.mn.us and tate.mn.us RRECTION FOR EACHIT INCLUDE ALL OF THORMATION: what has been, or will be ency. oposed, completion dat r title of the person rection and monitoring tence of the deficiency. er Hopkins was construction and is of Type II(222) as built in 1960, is two-sis fully fire sprinkler prot (2) construction; ras built in 1965, is two-sis fully fire sprinkler prot (2) construction; as built in 1989, is two-sis fully fire sprinkler prot (2) construction; as built in 1989, is two-sis fully fire sprinkler prot (2) construction; 	IE e, done e. o cted as tories, ected stories, ected stories,	< 000				
	has no basement is and is of Type II(22 The most recent ac 2008, is one-story, sprinkler protected	as built in 1993, is two-s s fully fire sprinkler prote 2) construction; ddition was constructed has no basement, is ful and is of Type II(222)	ected in ly fire		10-00872	6	on short Page	2 05 4
FORM CMS-2	567(02-99) Previous Versions	Obsolete Even	ID: EKK721	Fa	acility ID: 00872	continuati	on sheet Page	2014

		AND HUMAN SERVICES		FC	TED: 11/13/2013 DRM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) 01 - MAIN BUILDING 01	DATE SURVEY COMPLETED
		245293	B. WING		10/28/2013
				TREET ADDRESS, CITY, STATE, ZIP CODE 25 SECOND AVENUE SOUTH	
GOLDEN	LIVINGCENTER - HO		F	IOPKINS, MN 55343	
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From pa construction.	age 2	K 000		
	detection in the cor corridors which is r department notificat building and the fiv construction type a existing health card surveyed as 1-build CMS-2786R bookl 01 in accordance v Care Occupancies with Chapter 18 Net	re alarm system with smoke rridors and spaces open to nonitored for automatic fire ation. Because the original e (5) additions meet the illowed for both new and e occupancies, the facility was ding and two (2) Form ets were completed; Building with Chapter 19 Existing Health and Building 02 in accordance ew Health Care Occupancies.			
K 046	The requirement a NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K 046	K 46	12-4-13
SS=F	Emergency lighting provided in accord	g of at least 1½ hour duration is ance with 7.9. 19.2.9.1.	1	 * The testing of the batter operated emergency light at the generator has been completed. * The testing of the batter 	
	Based on docume with staff, the facili emergency lighting tested in accordan 7.9, 19.2.9.1. This all residents, staff	is not met as evidenced by: entation review and an interview ity has failed to ensure that g has been maintained and ice with NFPA LSC (00) Section deficient practice could affect and visitors in the event of a generator failure.		<pre>operated emergency light at the generator has been set u to be completed monthly for 30 seconds and annually for 90 minutes. * The maintenance staff hav been trained on the regulation requiring monthly and annual testing of the battery operated emergency light.</pre>	76

		AND HUMAN SERVICES				FORM	11/13/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245293	B. WING	;		10/2	8/2013
NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/2	.0/2010
	LIVINGCENTER - HO				25 SECOND AVENUE SOUTH		
GOLDEN				F	HOPKINS, MN 55343		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 046	on 10/28/13, during interview with the M revealed that there monthly 30 second	veen 12:30 PM and 3:30 PM documentation review and an faintenance Supervisor, it was was no documentation of testing, and the annual 1 1/2 battery powered emergency	K	046	* Monitoring to ensure	or s to	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: EKK721	1	Fac	cility ID: 00872 If continu	ation shee	t Page 4 of 4