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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE 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 ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/01/2002**

6. DATE OF SURVEY 12/10/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **138** (L18)

13. Total Certified Beds **138** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date : (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist, 03/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00040** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/23/2013** (L33)

DETERMINATION APPROVAL

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.

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

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245293	A. Building B. Wing	12/10/2013

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	12/04/2013	ID Prefix F0226 Reg. # 483.13(c) LSC	12/04/2013	ID Prefix F0242 Reg. # 483.15(b) LSC	12/04/2013
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	12/04/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	12/04/2013	ID Prefix F0309 Reg. # 483.25 LSC	12/04/2013
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	12/04/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	12/04/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	12/04/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/MM	3/20/2014	18626	12/10/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/25/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245293	A. Building B. Wing **01 - MAIN BUILDING 01**	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) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0046	Correction Completed **12/04/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/cbl	01/16/2014	18626	12/09/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
10/28/2013	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245293	02 - 2008 ADDITION	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0046	12/04/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	01/16/2014	19251	12/09/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
10/28/2013		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE 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 ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (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
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2002**

6. DATE OF SURVEY **10/25/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited
1 TJC
2 AOA
3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B,8*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Rebecca Wong, HFE NEII — 11/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 3/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/23/2013
(L33)

DETERMINATION APPROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EKK7

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 teh 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - 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)

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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING ______ B. WING ______	10/25/13 per GD ~~10/24/2013~~

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted the Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in the Title 18 and Title 19 programs. This Plan of Correction is submitted as a the facility's credible allegation of compliance.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	Accepted 11-25-13 [signature]	12-4-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Interim Executive Director (X6) DATE: 11/21/13

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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse to the State agency (SA) immediately for 1 of 4 residents (R222) reviewed for alleged abuse. Findings include: A review of the event reporting logs from 12/6/12, and going forward revealed a complaint of sexual abuse. The event report noted on 9/29/13, at 8:00 p.m. on the ACU (memory care) unit the "nursing assistant [NA] reported to charge licensed practical nurse [LPN] that R214 was observed sitting on a bed in an empty room alongside R222. R214 had his hand down the pants of R222. The residents were told by the NA that it would be best to leave the room and both residents got up and left. Both residents have advanced dementia, nonsensical conversation and cannot be interviewed, neither resident sustained injuries."	F 225	F 225 * All allegations of abuse for resident R222 will be reported immediately to the State Agency. * All allegations of abuse for all vulnerable adults residing in the facility will be reported immediately to the State Agency. * All facility staff have been educated on the requirement of immediate reporting of all alleged resident abuse under the Vulnerable Adult Law. All facility staff have been educated on the facility's procedures to encompass immediate reporting of all alleged abuse. * Monitoring to ensure compliance will be conducted by the DNS through the vulnerable adult reporting and tracking logs maintained by the facility. * The facility QAPI committee will review the status of immediate vulnerable adult reporting quarterly for further recommendations. * The date of completion is 12-4-13.	

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F 225	Continued From page 2 R222 had a diagnosis of dementia on the admission Minimum Data Set (MDS) dated 9/19/13. R222 had a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. R222 was unable to complete the additional mental status exam to determine decision making skills due to inattention and disorganized thinking. R214 had diagnosis of Alzheimer's disease on the admission MDS dated 8/26/13. R214 had a BIMS score of 99 indicating he was unable to complete the assessment, and had severely impaired daily decision making skills and rarely or never made decisions. On 9/30/13, at approximately 9:00 a.m. the incident was reported to the SA by the director of nursing (DON). The investigative report was submitted 10/4/13. The incident was not reported to the SA immediately (five days later). On 10/24/13, at 12:36 p.m. the administrator verified the report was submitted late report to the SA. On 10/24/13, at 12:56 p.m. the DON stated it was a fairly new nurse who had received the training on abuse prevention and reporting in orientation. "I think it just didn't cross her mind, so when we heard about it in morning report, we called it in right away." The DON did acknowledge the report was submitted late to the SA.	F 225	 RECEIVED NOV 25 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226	F226 * All allegations of abuse for resident R222 will be reported immediately to the	12-4-13

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F 226	Continued From page 3 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all allegation of sexual abuse were reporting immediately to the State agency (SA) for 1 or 4 residents (R222) reviewed for reportable events. Findings include: A review of the facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements dated April 2008, and last revised Mar 2012, revealed: The section under Reporting section B, noted the facility was to determine whether the incident was reportable and then report the incident. Also noted in the same section and under Abuse, the policy directed the facility to look at the actions that constitute abuse and attempts of abuse which included verbal, sexual, physical and mental abuse and included resident to resident abuse regardless if serious harm occurred. A review of the event reporting logs from 12/6/12, and going forward revealed a complaint of sexual abuse. The event report noted on 9/29/13, at 8:00 p.m.	F 226	State Agency. * All allegations of abuse for all vulnerable adults residing in the facility will be reported immediately to the State Agency. * All facility staff have been educated on the requirement of immediate reporting of all alleged resident abuse under the Vulnerable Adult Law. All facility staff have been educated on the facility's procedures to encompass immediate reporting of all alleged abuse. * Monitoring to ensure compliance will be conducted by the DNS through the vulnerable adult reporting and tracking logs maintained by the facility. * The facility QAPI committee will review the status of immediate vulnerable adult reporting quarterly for further recommendations. * The date of completion is 12-4-13.	

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F 226	Continued From page 4	F 226		

on the ACU (memory care) unit the "nursing assistant [NA] reported to charge licensed practical nurse [LPN] that R214 was observed sitting on a bed in an empty room alongside R222. R214 had his hand down the pants of R222. The residents were told by the NA that it would be best to leave the room and both residents got up and left. Both residents have advanced dementia, nonsensical conversation and cannot be interviewed, neither resident sustained injuries." The investigative report concluded with actions taken to prevent recurrence: included 15 minute checks of R214 to help staff monitor his whereabouts. The staff are attempting to keep R214 and R222 apart from each other and engaged in the activity programing. The staff are also allowing R222 and R214 to sit together only in a supervised setting. The plan lacked a specific time limit of how long the 15 minute observations were to be conducted.

R222 had a diagnosis of dementia on the admission Minimum Data Set (MDS) dated 9/19/13. R222 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated server cognitive impairment. R222 was unable to complete the additional mental status exam to determine decision making skills due to inattention and disorganized thinking.

R214 had diagnosis of Alzheimer's disease on the admission MDS dated 8/26/13. R214 had a BIMS score of 99 which indicated he was unable to complete the assessment, and had severely impaired daily decision making skills and rarely or never made decisions.

On 9/30/13, at approximately 9:00 a.m. the

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 5 incident was reported to the SA by the director of nursing (DON). The investigative report was submitted 10/4/13. The incident was not reported to the SA immediately On 10/24/13, at 12:36 p.m. the policy statements that failed to meet Federal regulations were reviewed with the administrator of the facility. On 10/24/13, at 12:56 p.m. the DON stated it was a fairly new nurse who had received the training on abuse prevention and reporting in orientation, "I think it just didn't cross her mind, so when we heard about it in morning report, we called it in right away." The DON did acknowledge that the facility was a late in reporting to the SA.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident preferences were accommodated for bathing for 2 of 3 residents (R113, R15) reviewed for choices in daily routine. Findings include:	F 242	F 242 * The residents R113 and R15 will have their preferences assessed and accommodated for bathing. * All residents will have their preferences assessed and their requests for bathing accommodated. * The Clinical Nurse Managers have been educated on the revised Resident Preference Questionnaire and the schedules for completion to ensure resident preferences are accommodated. * Monitoring to ensure compliance will be conducted through random resident satisfaction audits completed by the Licensed Social	12-4-13

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

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F 242	Continued From page 6 R113's preference of having more than one bath or shower in a week was not accommodated. R113 informed staff he wanted to have more than one bath during the week; however, her preference was not honored. During an interview with R113 on 10/22/13, at 9:52 a.m. the resident stated he had "no choice" regarding how many times he bathed or showered during a week. R113 stated he could take a shower "only once a week". R113 explained his preference was to take "three times a week a shower", as he used to do so previously through his life prior coming to the facility. R113 explained he wanted to take shower at least two times a week, he stated he "was not always clean", at times had "accidents with bowel movement", and not being clean all the time "bothered "him quite a bit. R113 also stated he told staff about wanting more often showers, but staff "didn't listen" to him, so he just gave up. R113 was interviewed again on 10/23/13, at 9:21 a.m. when he stated again taking shower only once a week bothered him because he "didn't feel clean." R113 also stated nobody asked him about his preference of how many times a week he wanted to shower or a bath, and he felt he had no choice. Although R113's significant change Minimum Data Set (MDS) dated 8/5/13, indicated his cognition was severely impaired (Brief Interview for Mental Status or BIMS score was 6), during interviews on 10/22/13, and on 10/23/13, R113 answered the interview questions consistently. Per the MDS, R113 needed total assistance of one staff with bathing needs.	F 242	Workers. * The facility QAPI committee will review the status of the resident satisfaction audits quarterly for further recommendations. * The date of completion is 12-4-13.	

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F 242	Continued From page 7 The Quarterly Interdisciplinary Resident Review dated 8/5/13, Clinical Health Status dated 5/25/13, did not include resident activities of daily living preference assessment. The ACU (Alzheimer's Care Unit) Psychosocial Progress Note dated 8/24/13, 5/18/13, and 2/20/13 did not include preference assessment. The physical functioning care plan dated 9/8/10, and last revised on 10/13, indicated "Encourage choices with cares", however the care plan did not indicate resident's choice regarding bathing frequency. Per the plan of care, R113 was diagnosed with dementia with plan to long term at the facility on the secured Alzheimer's unit. The Clinical Manager of the ACU unit, also registered nurse (RN)-C was interviewed on 10/23/13, at around 10:55 a.m. RN-C verified R113 was on the bathing schedule once a week, and explained resident's preference assessment was completed upon admission, which was started only two years ago. The RN-C verified R113's record and stated a preference assessment might have not been completed since he has been in the facility for over three years. The RN-C further explained that every resident was scheduled for once a week shower or a bath, and if a resident preferred more than once a week shower, it was up to the resident or family members to bring that into the staff's attention. R15's preference of having more than one bath or shower in a week was not accommodated. R15 informed staff she wanted to have more than one bath during the week; however, his preference	F 242		

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F 242	Continued From page 8 was not honored. R15 was observed in his room on 10/22/13, at 11:18 a.m. R15 explained he was legally blind, saw only some shadows. During interview R15 stated he had "no choice" regarding how many times he bathed or showered during a week. R15 stated he could take a shower "only once a week." R113 explained his preference was to "take a bath at least two times a week." R15 also explained once a week shower was "not enough" for him, it made him feel "dirty". He also stated due to his eye sight he needed staff's assistance with the bathing process. R15 also stated he told to staff member he wanted more often showers, a few days later the clinical manager came and told him that was not possible, however he have not given him an explanation. R15 further explained staff did not ask him about his bathing frequency preference. R15's quarterly MDS dated 9/26/13, indicated R15's cognition was moderately impaired (BIMS score was 9). Per the MDS, R15 needed physical assistance of one staff with bathing needs, and R15's diagnoses included: hypertension, diabetes, seizures disorder and schizophrenia. The Resident Preference Questionnaire dated 10/18/12, noted R15's day shift versus evening shift bath preference was assessed, however the questionnaire did not contain question regarding residents bath frequency preference. R15's self care deficit care plan dated 10/4/13, indicated "Encourage choices with cares", and "Assist of 1 w [with]/ shower/bath as scheduled". The care plan did not indicated R15's choice regarding bathing frequency.	F 242		

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F 242	Continued From page 9 The clinical manager, also licensed practical nurse (LPN)-B was interviewed on 10/23/13, at 11:43 a.m. and stated residents preferences were assessed upon admission, at care conferences, and acknowledged residents were not "Officially " asked about their shower/ bath frequency preference. The LPN-B verified there was no formal assessment regarding resident's shower/bath frequency preference. The LPN-B could not remember if he had a discussion or not with R15 about his shower schedule. The director of nursing (DON) was interviewed on 10/24/13, at 11:43 a.m. The DON explained the Resident Preference Questionnaire was created by her two years ago, and verified the questionnaire did not include question about resident's shower/bath frequency preference. The DON stated the facility did not have a policy for daily routine preference assessment.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F 279 * The plan of care for R56 is developed to include the ambulation guidelines as recommended upon discharge from therapy. The plan of care for R214 is developed to include psychotropic medication use. * The plans of care for all residents requiring ambulation programs have been developed to encompass the current ambulation program. The plans of care for all residents receiving psychotropic medications have	12-4-13

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F 279

Continued From page 10

psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to develop a plan of care for ambulation recommended by therapy for 1 of 1 resident (R56) reviewed for rehabilitation services. In addition, the facility failed to develop a care plan for psychotropic drug use for 1 of 1 resident (R214).

Findings include:

Ambulation:
R56 was admitted to the facility on 7/12/13. The Nursing Home Visit note dated 7/15/13, noted R56 had diagnoses which included rhabdomyolysis, history falls, deconditioning and weakness. R56's care plan lacked development of an ambulation program per therapy recommendations.

R56's Minimum Data Set (MDS) dated 9/18/13, indicated R56 required extensive physical assist of one with bed mobility, toileting and transfers. In addition, the MDS did not have information on the resident's ability to transition from sit to stand, walk/ambulate in the room or corridor.

Although the care plan dated 7/14/13, directed staff to assist R56 with transfers, ambulation, bed mobility, repositioning and range of motion. Care

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been developed.
* Clinical Nurse Managers have been educated on the requirement to develop a care plan to encompass ambulation recommendations for all residents requiring an ambulation program. The education also included the requirement for all ambulation programs to be documented on the TAR and incorporated on the nursing assistant team sheets. Clinical Nurse Managers and Licensed Social Workers have been educated on the requirement to develop a care plan for all residents receiving psychotropic medications.
* Monitoring to ensure compliance will be conducted through random audits of care plans, TARs, and team sheets for those residents requiring an ambulation program. Random audits will also be completed of the care plans for residents receiving psychotropic medications.
* The facility QAPI committee will review the results of the ambulation and psychotropic medication audits quarterly for further recommendations.
* The date of completion will be 12-4-13.

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plan goal "Will continue to ambulate with assist up to 50 feet." On 10/25/13, PT paced off the distance from R56's room to the dining room table and stated it was approximately 140 feet each direction. The care plan failed to address the physical therapy (PT) recommendation to ambulate R56 to and from meals as the plan of care still directed the staff to ambulate R56 50 feet.

On 10/23/13, at 7:55 a.m. nursing assistant (NA)-A and NA-B were observed to assist R56 stand with a transfer belt and walker. During transfer NA-A cued R56 to turn to his right side as NA-B guided R56's arm to the wheelchair arm rest. During transfer R56 stood, had short, shuffling steps and walked approximately five feet then sat down in the wheelchair.
-At 8:13 a.m. NA-B was observed propelling R56 in the wheelchair past the nursing station to the dining room.

On 10/23/13, at 2:10 p.m. NA-A stated she ambulated R56 from outside his room to the dining room before lunch but had not ambulated R56 back from the meal.

On 10/24/13, at 12:40 p.m. licensed practical nurse manager (LPN)-B stated there was a communication breakdown that R56 needed to be ambulated per recommendation made upon discharge from therapy, when R56 was transferred from 1 West to 2 East. LPN-B went on to state that when R56 transferred to unit, LPN-B had noted on the 2 East nursing assistant assignment sheets R56 was ambulating and on 10/18/13, LPN-B had ambulated the resident 100 feet to see his ability. In addition, LPN-B verified there was no documentation of R56 ambulating

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from 9/17/13 until 10/18/13. LPN-B stated he would take responsibility for not ensuring the ambulation program recommended by PT was implemented upon transfer to 2 East on 9/26/13.

On 10/25/13, at 7:25 a.m. the Transitional Care Unit (TCU)/1 West registered nurse manager (RN)-A stated R56 has used a lift to transfer on admission to TCU, towards the end of his stay in TCU he had changed to assist of 1 with transfer. She stated "I knew he was walking with PT but I could not remember if he was walking with nursing." RN-A further stated "if someone were ambulating, it would be on the team sheet; normally if physical therapy was completed and resident was supposed to be ambulated it would be put on the treatment administration record (TAR)." RN-A further stated she did not have a copy of the team sheet from when R56 was at TCU to look back if R56 had been on a walking problem as R56 remained in TCU for nine days prior to being moved to 2 East.

On 10/25/13, at 8:01 a.m. RN-A again stated "Usually when a resident transferred to another unit, social service moved the belongings, the nurse moved the medications, the chart and reported to the floor nurse. The clinical manager (CM) reported to the CM of the receiving unit to relay the team sheet information." RN-A vaguely remembered R56's transfer and believed she gave a verbal report to LPN-B. RN-A further stated she used the Point Click Care (PCC) Kardex to report if assistance was needed and basically everything on the team sheet was reported. RN-A went on to state "If the CM wasn't there I would leave it (the PCC Kardex) on his desk."

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On 10/25/13, at 8:18 a.m. LPN-B stated cares provided to R56 included transfers with assist of one with transfer belt, working on wounds (vascular ulcers on left leg and right foot 2nd digit), and underlying osteomyelitis. "The goal was to get him back to assisted living." LPN-B did remember getting a verbal report from RN-A. LPN-B pulled up and printed the PCC Kardex for R56 which indicated ambulation with assist of one. LPN-B verified he had not updated the PCC Kardex after transfer.

On 10/25/13, at 9:34 a.m. the director of nursing (DON) verified the care plan for R56 failed to identify R56 was on an ambulation program as per therapy recommendation. The DON further stated she would expect to see the care plan, TAR, and team sheet filled out with matching information per therapy recommendation. She also verified LPN-B had not written the care plan as recommended by therapy.

Psychotropic medication:
R214's Admission Record indicated R214 was admitted to the facility on 8/19/13, with diagnoses which included Alzheimer's disease and dementia without behavioral disturbances. R214's care plan was not developed to identify risk factors, goals, and interventions for the use of Seroquel (an antipsychotic medication).

The current electronic Physician's Orders indicated: "SEROguel tablet Give 25 mg [milligram] by mouth two times a day for ANTIPSYCHOTIC" with an 8/30/13, start date.

The admission MDS dated 8/30/13, noted R214 have not any behaviors such as delirium, hallucinations, disorganized thinking, altered level

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F 279	Continued From page 14 of consciousness, or any other behaviors such as verbal, physical behavioral symptoms directed towards others. The admission Care Area Assessment (CAA) dated 8/30/13, indicated "resident displays behaviors r/t [related to] Alzheimer's and receives medication to manage and treat condition." The CAA did not indicate what kind of behaviors R214 had. R214's care plan dated 8/19/13, was reviewed. The care plan lacked indication for the Seroquel use, there were no risks, goals, target behaviors, or non-pharmacological interventions identified. RN-C/clinical manager was interviewed on 10/24/13, at approximately 1:10 p.m. RN-C explained when she wrote a care plan for antipsychotic medication use she usually included information regarding: medication use as ordered, side effect monitoring, target behavior monitoring, pharmacist consults, non-pharmacological interventions, and referrals to psychologist as needed. RN-C reviewed R214's record and confirmed the lack of care planning of the psychotropic medication (Seroquel) use. The Behavior Management Guidelines revised in 2013, noted in the Assessment/Care Planning section "Licensed nursing staff completes the Plan of Care following identification of antipsychotic medication usage or behavioral concerns."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F 282 * The residents R39 and R56	12-4-13

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The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, document review and interview, the facility failed to provide nail cares as directed by the plan of care for 2 of 3 residents (R39, R56) in the sample who were dependent upon staff for nail cares. In addition, the facility failed to follow the care plan for fluid restriction for 1 of 1 resident reviewed for dialysis (R97).

Findings include:

R39 on 10/22/13, at 10:12 a.m. was observed to have approximately half (1/2) inch long fingernails on both hands. The nails were observed to have a buildup of brownish colored soil under the nail.

During continuous observations on 10/23/13, from 6:46 a.m. through 9:19 a.m. R39 was observed to have half inch long and soiled fingernails on both hands. At no time during the observation was nail care offered or provided to R39.

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 had upper and lower dentures, used a wander

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have been provided nail care as directed by the plan of care. The resident R97 has been provided fluid restriction as directed by the plan of care.

* All residents will receive nail care as directed on their plan of care. All residents will receive fluid restrictions as directed by their plan of care.

* All nursing staff have been educated on the requirement to provide nail care as directed by the plan of care. Licensed nurses will be educated on the requirement to document the status or refusal of nail care on the Comprehensive Skin Assessment forms. All nursing staff and dieticians will be educated on the requirement to follow the plan of care for residents requiring fluid restrictions and the facility protocols to communicate and document adherence to the fluid restrictions.

* Monitoring to ensure compliance will be conducted through random grooming/nail care audits in conjunction with grooming care plan audits and Comprehensive Skin Assessment audits. Random audits will also be conducted for residents receiving fluid restrictions to ensure fluid

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F 282	Continued From page 16 guard at all times, was independent with transfers, independent with ambulation with a walker, was continent of bowel, incontinent of bladder and required a "Toileting Plan." The special instructions section of the sheet directed, "Alert X2 [times two]. Assist w/ [with] Bathing, Grooming, & Dressing, Reapproach [sic], if he refuses." R39's care plan for self-care deficit dated 10/28/11, identified R39's risks associated with deficit. The care plan directed, "Nail care weekly & PRN [as needed]." On 10/23/13, at 11:11 a.m. the licensed practical nurse manager (LPN)-B verified the care plan directed to offer nail care weekly and as needed. On 10/24/13, at 2:11 p.m. the director of nursing (DON) stated her expectation was to have all residents well groomed. DON stated "a lot" of residents were resistive with cares and had other mental illnesses. DON stated staff should "do a better job" documenting in the space provided; if nail care was not provided, was refused and if staff re-approached the resident. R56 was not provided assistance with nail care. R56 was observed to have long, soiled fingernails during the evening on 10/21/13, and during subsequent days of the survey, 10/22/13 and 10/23/13, during continuous observations R56's fingernails remained long and soiled, at no time during the observation was nail care offered to R56. R56's 60-day Minimum Data Set (MDS) dated 9/11/13, identified R56 required limited physical	F 282	restrictions are being provided per care plan. * The facility QAPI committee will review the results of the care plan grooming audits and fluid restriction audits quarterly for further recommendations. * The date of completion will be 12-4-13.	

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F 282	Continued From page 17 assist of one staff with personal hygiene needs. The Comprehensive Assessment Summary dated 7/27/13, indicated R56 required assist of one with bed mobility, transfers, dressing, toileting, bathing and personal hygiene. The Care plan dated 7/14/13, identified resident with physical functioning and self-care deficit related to rhabdomyolysis, glaucoma, anemia, and congestive heart failure. The Goal "will be well dressed, groomed and free of odor." The nursing assistant assignment sheet " Team 1-Apha" directed R56 required assist with bathing, grooming, and dressing. The "2 E South Shower Schedule" directed R56 to receive a shower/bath on evening shift (PM) on Monday. Review of the July through October 2013 Comprehensive Skin Assessment indicated R56 had nail care completed 7/30/13 and 10/7/13. In addition nail care had been circled " No " three times with no reason as to why nail care was not completed on 7/23/13, 10/14/13, 10/21/13, there was no documentation of nail care provided or not provided on 9/30/13. On 10/23/13, at 9:36 a.m. LPN-C stated his expectation was all resident's cares were to be done per care plan and he expected all the residents to get quality care. In addition, LPN-C stated if he saw a resident during the day not shaven or needing grooming he would remind the nursing assistants to make sure it is done by the end of his shift. On 10/23/13, at 9:54 a.m. NA-A stated she had completed providing morning cares R56, but would check later and toilet him. On 10/23/13, at 11:14 a.m. LPN-C verified the	F 282		

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F 282	Continued From page 18 nails were long and soiled and stated "they are a little long and need to be clipped" stated nail care is done on the resident's bath day but aides needed to check and do it daily as soon as they see the nails were long. Additionally R56 stated he remembered staff cutting his nails in the past and then stated " I like to have them long to pick my nose " then looked at surveyor and nurse with a smile and stated " Am joking." On 10/24/13, at 12:50 p.m. LPN-B stated nail care was done weekly with the bath for all the residents and if a resident preferred to keep their nails long then would honor their wish. LPN-B verified that R56 did not have a care plan that indicated a wish for long nails. LPN-B also verified R56's nail care was circled "NO" on 10/14/13 and 10/21/13, and there was no documentation as to why nail care was not completed especially on 10/21/13-Monday. LPN-B further stated he expected staff to assist resident with grooming according to the plan of care. On 10/24/13, at 2:11 p.m. the DON stated her expectation was to have all resident's well groomed. DON stated "a lot" of residents were resistive with cares and had other mental illnesses in the unit. DON further stated "staff should do a better job documenting in the space provided; if nail care was not provided, was refused and if staff re-approached the resident." On 10/25/13, at 9:34 a.m. the DON stated their policy for licensed staff to do nail trimming only included diabetics, it would be on the treatment administration record (TAR) for the licensed nurses to do. The DON further stated the policy did not include residents on Coumadin.	F 282		

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On 10/25/13, at 10:00 a.m. the DON verified trimming of nail care was on the September TAR and had been signed off once on 9/13/13, but was not on the TAR after resident transferred units. DON stated "I don't know why that would say 2 East on the date indicated." DON further stated was not sure why the TAR was different after resident moved from one unit to the other.

R97 had diagnoses including end stage renal disease, congestive heart failure and diabetes per review of the current electronic physician's orders. The physician's order dated 6/17/13, noted R97 had a left arm shunt/fistula, was on dialysis Mondays and Friday, and R97 was on a 1200 milliliter (ml) fluid restriction. The facility did not ensure physician ordered fluid restrictions were implemented and encouraged as indicated in the plan of care which potentially contributed to R97's weight gain.

R97's care plan last revised on 10/4/13, indicated "Fluid restriction as ordered."

The Fluid Administration plan dated 6/18/13, noted the 1200 ml per day fluid restriction and the plan directed staff:
- "Dietary Provides: Breakfast= 240 ml
  Lunch= 240 ml
  Dinner=240 ml
- Supplements: Nephro 4 oz BID [twice daily] = 240 ml
- Nursing Provides: 7:00 med [medication] pass =60 ml
  11:30 med pass =60 ml
  15:00 med pass =60 ml
  20:00 med pass = 60 ml "

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R97 was observed eating breakfast on 10/23/13, at 8:11 a.m. R97 drank approximately 240 cc apple/ cranberry juice and 240 cc hot tea. The dietary slip did not indicate R97 was on 1200 cc fluid restrictions.

R97 was observed in her room on 10/23/13, at 10:35 a.m., with a white water pitcher on the bedside table.

R97 was observed again on 10/24/13, at 9:19 a.m. lying in the bed. There was a white water pitcher on the bedside table with an 8 ounce (oz.) plastic cup halfway full with water. R97 was interviewed at the time, and explained her memory was bad, and she could not remember if she had been told about the fluid restrictions order. R97 stated once a day staff bring a water pitcher full with water. R97 also stated she only knew that she shouldn't drink too much.

The NA-D, who was assigned to provide cares to the resident was interviewed on 10/24/13, at 9:19 a.m. and stated R97 was provided daily with water in the white pitcher, and received a refill as needed. NA-D stated R97 was not on fluid restriction. Review of the care assignment sheet indicated "*Fluid restrictions", however the care assignment sheet did not provide any additional directions regarding how much fluid staff could provide R97.

LPN-D was interviewed on 10/24/13, at 10:07 a.m. and stated he did not know off the top of his head if R97 was on fluid restriction. LPN-D reviewed the electronic medication administration record (MAR) and TAR, and did not find any indication regarding the fluid restrictions. LPN-D proceeded to review the physician's orders and

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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. 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# - 10/21/13: 150.6# 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	F 282		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 22 much fluids intake. LPN-B, was interviewed on 10/24/13, at 10:55 a.m. and stated R97 was not supposed to receive a water pitcher in her room. The DON was interviewed on 10/24/13, at 12:51 p.m. and explained a resident's fluid restriction orders were communicated to the nursing staff through team assignment sheet for the aids, and the plan was outlined for the licensed staff on the electronic (e) MAR. Per the DON staff was also expected to follow the fluid restriction plan. The DON also explained the e-MAR had to reflect how much fluid was to be given with each medication administration. The DON reviewed R97's e-mar and verified that although it indicated R97 was on 1200 ml fluid restriction, there was no outlined plan for nurses to follow. The Fluid restriction, undated, policy indicated "All fluid restrictions are ordered by the physician. Responsibility for fluid allotment is divided between the Dining Services and the Nursing department".	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	F 309 * 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 maintain the fluid restrictions. * All nursing staff and dieticians have been educated	12-4-13

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F 309	Continued From page 23 by: Based on observation, interview and document review, the facility failed to provide care and services related to fluid restrictions for 1 of 1 resident (R97) reviewed for dialysis. Findings include: The facility did not ensure physician's ordered fluid restrictions were implemented and encouraged, which potentially have contributed to R97's weight gain. Review of the current electronic physician's orders indicated R97 had diagnoses including end stage renal disease, congestive heart failure and diabetes. The physician's order dated 6/17/13, noted R97 had a left arm shunt/fistula, was on dialysis Mondays and Friday, and R97 was on 1200 milliliter (ml/cc) fluid restrictions. R97 was observed eating breakfast on 10/23/13, at 8:11 a.m. R97 drank approximately 240 cc apple/cranberry juice and 240 cc hot tea. R97's dietary slip did not indicate R97 was on 1200 cc fluid restrictions. R97 was observed in her room on 10/23/13, at 10:35 a.m., with a white water pitcher on the bedside table. R97 was observed again on 10/24/13, at 9:19 a.m. lying in the bed. There was a white water pitcher on the bedside table with an 8 ounce (oz.) plastic cup halfway full with water. R97 was interviewed at this time, and explained her memory was bad, and could not remember if she was told before about the fluid restrictions orders, and staff gave her once a day a water pitcher full	F 309	on the facility protocols to communicate and document adherence to resident fluid restrictions. The education included the requirement to outline fluid restrictions on the plan of care, the nursing assistant team sheet, and the fluid administration plan for meals and medication passes outlined on the e-MAR. * Monitoring to ensure compliance will be conducted through random audits of care plans, team sheets, and e-MARs for residents receiving fluid restrictions. * The facility QAPI committee will review the results of the fluid restriction audits quarterly for further recommendations. * The date of completion will be 12-4-13.	

F 309 Continued From page 24 F 309

with water. R97 also stated she only knew that she should not drink too much.

The nursing assistant (NA)-D, who was assigned to provide cares to the resident was interviewed on 10/24/13, at 9:19 a.m. and stated R97 was provided daily with a water in the white pitcher, and received refill as needed. NA-D stated R97 was not on fluid restrictions. Review of the care assignment sheet indicated "*Fluid restrictions", however did not provide any additional directions regarding how much fluid staff could provide R97.

The licensed practical nurse (LPN)-D was interviewed on 10/24/13, at 10:07 a.m. and stated he did not know off the top of his head if R97 was on fluid restrictions. LPN-D reviewed the electronic medication administration record (MAR) and treatment administration record (TAR), and did not find any indication regarding the fluid restrictions. LPN-D proceeded to review the physician's orders and found the 1200 cc fluid restriction order. The LPN-D verified the electronic MAR and TAR did give clear instructions regarding how much fluid nursing staff supposed to administer to R97 in order to comply with the fluid restriction orders.

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#

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	245293	A. BUILDING ____ B. WING ____	10/25/13 per GD ~~10/24/2013~~

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GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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F 309	Continued From page 25	F 309		

- 10/4/13: 151#
- 10/11/13: 149#
- 10/18/13: 151.6#
- 10/21/13: 150.6#

The most current nutritional assessment dated 10/14/13, indicated R97 was on 1200 cc fluid restriction, and R97's weights were "increased from her UBW [usual body weight] by a few pounds, likely r/t [related to] noncompliance with FR [fluid restrictions]."

R97's care plan last revised on 10/4/13, indicated "Fluid restriction as ordered."

The Fluid Administration plan dated 6/18/13, noted the 1200 cc per day fluid restriction and the plan directed staff:
- Dietary Provides: Breakfast= 240 ml
  Lunch= 240 ml
  Dinner=240 ml
- Supplements: Nephro 4 oz BID [twice daily] = 240 ml
- Nursing Provides: 7:00 med [medication] pass =60 ml
  11:30 med pass =60 ml
  15:00 med pass =60 ml
  20:00 med pass = 60 ml

R97's dietary meal card for breakfast, noon and evening did not include any information regarding fluid restrictions.

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 this plan was placed in the intake and output book, and dietary staff was

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F 309	Continued From page 26 also provided with a copy. The RD also stated R97 was not supposed to receive water in the water pitcher for consumption, however she have "removed a water pitcher yesterday from her room." The RD was not aware R97 was provided regularly with the water pitcher, which the RD verified was 24 oz. (720 ml). The RD also stated she have noticed R97's weight have gone up slightly in the past several weeks, which could have been related to too much fluids intake. The LPN-B, also nurse manager was interviewed on 10/24/13, at 10:55 a.m. and stated R97 was not supposed to receive water pitcher in her room. The director of nursing (DON) was interviewed on 10/24/13, at 12:51 p.m. and explained a resident's fluid restriction orders were communicated to the nursing staff through team assignment sheet for the aids, and the plan was outlined for the licensed staff on the electronic (e) MAR. Per the DON staff was also expected to follow the fluid restriction plan. The DON also explained the e-MAR had to reflect how much fluid was to be given with each medication administration. The DON reviewed R97's e-mar and verified that although it indicated R97 was on 1200 cc fluid restriction; there was no outlined plan for nurses to follow. The Fluid restrictions undated policy indicated "All fluid restrictions are ordered by the physician. Responsibility for fluid allotment is divided between the Dining Services and Nursing department."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311	F 311 * The residents R39 and R56	12-4-13

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F 311	Continued From page 27 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance for 2 of 3 residents (R39, R56) who were unable to independently complete nail cares. In addition, the facility failed to ensure ambulation was provided as recommended by therapy for 1 of 1 resident (R56) reviewed for ambulation. Findings include: Nail care: R39 was not provided assistance with nail cares. On 10/22/13, at 10:12 a.m. R39 was observed to have approximately half (1/2) inch long fingernails on both hands. The nails were observed to have a buildup of brownish colored soil under the nail. During continuous observations, the following was observed: On 10/23/13, at 6:46 a.m. R39 was observed to be dressed for the day. The fingernails on both R39's hands remained long and soiled on both hands. The edges of the nails appeared jagged and uneven. R39 wheeled himself into the shower room and used the toilet. - At 6:56 a.m. while R39 wheeling himself down the hallway after toileting, a nursing assistant (NA)-C noted R39's shirt was soiled and verbally encouraged him to change his shirt. R39 repeatedly stated, "No." The licensed practical	F 311	have been provided nail care as directed by the plan of care. The resident R56 has been provided ambulation as recommended by therapy. * All residents will receive nail care as directed on their plan of care. All residents will receive ambulation assistance as directed on their plan of care and as recommended by therapy. * All nursing staff have been educated on the requirement to provide weekly and as needed nail care to all residents. Education will include the requirement for licensed nurses to document weekly the completion or refusal of nail care on the Comprehensive Skin Assessment Forms. All nursing staff have been educated on the requirement to have resident ambulation programs on the plan of care, documented when completed on the e-TAR, and incorporated on the nursing assistant team sheets. * Monitoring to ensure compliance will be conducted through random grooming/nail care audits in conjunction with grooming care plan audits and Comprehensive Skin Assessment form audits. Random audits will also be conducted of care plans,	

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F 311	Continued From page 28 nurse manager (LPN)-B was present at the time and directed to NA-C to "re-approach after he [R39] cools down." R39 remained in the wheelchair near the television (TV) area of the unit. - At 7:00 a.m. nursing assistant (NA)-C stated she was trying to convince R39 to change his shirt, because he "likes to wear them for several days" because "they're not dirty." NA-C stated she re-approached R39 and would continue to do so. NA-C stated R39 had a shower "yesterday [10/22/13]" and explained R39 required assistance with grooming. NA-C verified she was assigned to care for R39 that morning. - From 7:00 a.m. through 7:45 p.m. R39 remained up in the wheelchair and moved between the TV area, the small dining room and the hallways of the unit. - At 7:45 a.m. R39 wheeled himself in to the small dining room and remained in the room for coffee and the breakfast meal until 8:48 a.m. - At 8:48 a.m. R39 wheeled himself slowly out of the dining room and down the hallway to the shower room and transferred himself to the toilet independently at 8:51 a.m. - At 9:02 a.m. LPN-B knocked on the shower room door and asked if anyone was in the shower room, R39 responded. LPN-B closed the door and NA-A entered and assisted R39. R39 then immediately wheeled out of room into the hall. - At 9:10 a.m. R39 wheeled himself to his room and watched TV quietly. R39 remained in his room until the end of continuous observations at 9:19 a.m. When asked if he had nail care offered, R39 laughed and shook his head no. - At approximately 9:40 a.m. NA-C explained she was aware of R39 having long nails and stated she did not offer to cut them. NA-C explained she was not trained to offer to cut fingernails during	F 311	TARs, and team sheets for those residents requiring an ambulation program. * The facility QAPI committee will review the results of the grooming and ambulation audits quarterly for further recommendations. * The date of completion will be 12-4-13.	

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F 311	Continued From page 29 the morning cares. NA-C stated she was unclear when nail care should be offered and referred the surveyor to speak with the nurse. NA-C verified R39 had a shower on 10/22/12, but was unclear if nail care was offered. - At approximately 9:50 a.m. the LPN-C stated he was not notified of a refusal for nail care for R39. LPN-C stated nail care for non-diabetic residents should be offered as needed. LPN-C explained diabetic residents had their nails cut by nursing staff only. LPN-C verified R39's nails were long, soiled and required trimming. LPN-C asked R39 if he could cut his nails, R39 agreed. - At approximately 10:00 a.m. LPN-B stated nail care was offered weekly on shower day. LPN-B reviewed the shower list and verified R39 had a shower on 10/22/13, but stated R39 could have refused the nail care. - At 10:03 a.m. LPN-B observed LPN-C beginning to cut R39's nails in the resident's room. LPN-B verified the nails were long and stated they were "thick and jagged." LPN-C verified he worked on 10/22/13, stated R39 had refused his nail care and verified he did not report the refusal to LPNM-B or offer to assist with nail cares. - At 11:11 a.m. LPN-B verified the documentation on the Comprehensive Skin Assessment was where R39's nail care refusal should have been documented. LPN-B verified the documentation indicated R39's nail care was not completed since 8/15/13. LPN-B stated although nail care may be offered by the NA or nurse, it may not have been documented and should have been. - At 12:09 p.m. when asked regarding the procedure for refusals of care, NA-C stated if a resident refused cares, staff were instructed to re-approach a "little bit later" and if the resident continued to refuse a care, to report the refusal to the nurse.	F 311		

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F 311	Continued From page 30 The Admission Record dated 6/1/13, indicated R39's diagnoses included Alzheimer's disease and dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 7/17/13, indicated R39 had a Brief Interview of Mental Status (BIMS, a tool used to determine cognitive losses) score of 7 (indicating moderate to severe cognitive impairment) and R39 required limited assistance with personal hygiene. The MDS indicated R39 had no mood or behavior problems. The Care Area Assessments (CAAs) dated 10/15/13 and 10/24/13, indicated the activities of daily living (ADL) CAA did not trigger. The Order Review Report reviewed R39's diagnoses and directed, "Complete comprehensive skin assessment & diabetic nail cares on bath day." The order was dated as started on 7/2/13, and signed by the physician on 9/11/13. The Comprehensive Skin Assessment form dated 10/22/13, indicated R39's skin was assessed during his shower. The assessment included a "Yes/No" to circle if R39's nail care was completed. The form was checked "no" and lacked documentation why in the space provided after. LPN-B pointed to the previous week and explained R39's nails were not cut then and R39 had "refused." When asked regarding nursing staff offering to cut R39's fingernails on days other than shower days, LPN-B verified staff should have offered nail care "at least three times" and if R39 refused, notify the nurse. LPN-B stated if R39 still refused, staff should have notified him. LPN-B stated he would then attempt to cut the nails himself. A blue binder labeled The Team 2 Assignment and Team Sheets contained nursing assistant assignment sheets (used to direct individual resident care needs). The sheet identified R39	F 311		

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F 311	Continued From page 31 had upper and lower dentures, used a wander guard at all times, was independent with transfers, independent with ambulation with a walker, was continent of bowel, incontinent of bladder and required a "Toileting Plan." The special instructions section of the sheet directed, "Alert X2 [time two]. Assist w/ [with] Bathing, Grooming, & Dressing, Reapproach [sic], if he refuses." R39's care plan for self-care deficit dated 10/28/11, identified R39's risks associated with deficit. The care plan directed, "Nail care weekly & PRN [as needed]." On 10/24/13, at 2:11 p.m. the director of nursing (DON) stated her expectation was to have all residents well groomed. DON stated "a lot" of residents were resistive with cares and had other mental illnesses. DON stated staff should "do a better job" documenting in the space provided; if nail care was not provided, was refused and if staff re-approached the resident. The facility lacked a policy regarding resident nail care, including frequency of resident nail care, staff responsible for nail care and risks associated with nail care, such as diabetes or anticoagulant use. R56 was observed to have long, soiled fingernails during the evening on 10/21/13 and during subsequent days of the survey, 10/22/13 and 10/23/13, the resident's fingernails remained long and soiled. On 10/21/13, at 6:15 p.m. during dining observation R56 was observed to be sitting in the dining room conversing with other resident around him was observed to have approximately a half inch soiled and long nails to both hands. Additionally resident was unshaven.	F 311		

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F 311	Continued From page 32	F 311		

On 10/22/13, 10:20 a.m. resident nails were observed nails were still long and untrimmed to both hands and unshaven face resident was lying in his bed stated was not feeling good and was resting.

On 10/23/13, during continuous observation:
-At 7:42 a.m. NA-A was observed returning to resident room and shut the door. At that time R56 was sitting at the edge of the bed. NA-A left the room.
-At 7:44 a.m. NA-A came back to room with NA-B to assist finish resident cares.
-At 7:45 to 7:47 a.m. NA-A left the room to get a wash basin stated she needed it to use to wash resident's bottom when he stands up.
-At 7:48 to 7:50 a.m. both NA-A and NA-B observed attempting to stand R56 who stated he was unsteady then sat him down immediately at the edge of the bed. After sitting R56 told NA-A "just lay me down and change me and wash up this is always easy for me." NA-B was observed assisting R56 with his feet to bed.
-At 7:51 to 7:53 a.m. NA-A observed assisting R56 with pericare and was giving him cues to turn side to side during cares, applying and to fasten the dignity product. During that time when R56 was turning to the left R56 stated "Woo..." and NA-B reached over and held R56's right hand and stated I will not let you fall. Nails still observed to be long and soiled approximately 1/2 inch long neither NA-A nor NA-B offered to trim R56's nails.
-At 7:55 a.m. observed NA-A and NA-B assist R56 to stand and with a transfer belt and walker. During transfer NA-A cued R56 to turn to his right side as NA-B lead R56 arm and walker to the wheelchair arm rest until R56 sat down on his wheelchair.

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-At 7:57 a.m. observed R56 sitting on his wheelchair and still was unshaven and with long soiled nails to both hands in his room.
-At 8:13 a.m. observed NA-B wheeling R56 past the nursing station to the dining room and R56 was shaven but still had long soiled nails.
-At 8:14 to 9:18 a.m. observed R56 in the dining room independently eating talking to other residents around the table. R56 stated the aide had shaven him and thought she had done a good job for now.

10/23/13, at 9:42 a.m. during a random observation R56 in his room visiting with another resident on his wheelchair, observed still to have long and soiled nails. R56 stated staff usually assisted him with clipping his nails and he verified the nails needed to be clipped.

The care plan dated 7/14/13, identified resident with physical functioning and self-care deficit related to rhabdomyolysis, glaucoma, congestive heart failure and cardiomyopathy. Goal "will be well dressed, groomed and free of odor." The nursing assistant assignment sheet "Team 1-Apha" directed resident required assist with bathing, grooming, and dressing. The "2E South Shower Schedule" directed R56 to receive a shower/bath on evening shift (PM) on Monday. R56's 60-day MDS dated 9/11/13, identified R56 required limited physical assist of one staff with personal hygiene needs. The Comprehensive Assessment Summary dated 7/27/13, indicated R56 required assist of one with bed mobility, transfers, dressing, toileting, bathing and hygiene.

Review of the July through October 2013 Comprehensive Skin Assessment indicated R56 had nail care completed 10/7/13, and 7/30/13. In

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F 311	Continued From page 34	F 311		

addition nail care had been circled "No" four times with no reason as to why nail care was not completed on 7/23/13, 10/21/13, 10/14/13and one time nothing was circle of the two options on 9/30/13.

On 10/23/13, at 9:36 a.m. LPN-C stated his expectation was all resident cares were to be done per care plan and he expected all the residents to get quality care. He further stated he expected the nursing assistants to always make sure resident call-light and all personal items are at reach before leaving the room and the aides also need to make sure the resident is safe. In addition LPN-C stated if he saw a resident during the day not shaven or needing grooming he would remind the nursing assistants to make sure it was done by the end of his shift.

On 10/23/13, at 9:54 a.m. NA-A further stated she had completed providing resident with morning cares but would check later and toilet him.

On10/23/13, at 11:14 a.m. LPN-C verified the nails were long and soiled and stated "they are a little long and need to be clipped" stated nail care was done on the resident bath day but aides needed to check and do it daily as soon as they see the nails were long. Additionally R56 stated he remembers staff cutting his nails in the past and then stated "I like to them long to pick my nose." Then looked at surveyor and nurse with a smile and stated "Am joking."

On 10/24/13, at 12:50 p.m. LPN-B stated nail care was done weekly with the bath for all the residents and if a resident preferred to keep their nails long then would honor their wish. LPN-B verified that R56 to keep long nails was not care

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F 311	Continued From page 35 planned. He also verified R56's nail care was circled "NO" on 10/14/13 and 10/21/13, and there was no documentation as to why nail care was not completed. LPN-B further stated he expected staff to assist resident with grooming according to the plan of care. On 10/24/13, at 2:11 p.m. the DON stated her expectation was to have all residents well groomed. DON stated "a lot" of residents were resistive with cares and had other mental illnesses at the unit. DON stated staff should "do a better job" documenting in the space provided; if nail care was not provided, was refused and if staff re-approached the resident. On 10/25/13, at 8:01 a.m. registered nurse (RN)-A stated nail care would not be on the treatment administration record (TAR) unless a nurse was required to do it, it just automatically gets done. RN-A could not understand how nail cares would fall off from PCC; "You only change the room number to transfer and I do not understand why R56 nail care was not continued in 2 East." On 10/25/13, at 9:34 a.m. the DON stated their policy for nail trimming only included diabetics, it would be on the TAR for the licensed nurses to do and the policy did not include residents on Coumadin. On 10/25/13, at 10:00 a.m. the DON verified trimming of nail care was on the September TAR and had been signed off once on 9/13/13, but was not on the TAR after resident transferred units. DON stated "I didn't know why that would say 2 East on the date indicated."	F 311		

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F 311	Continued From page 36 The facility lacked a policy regarding resident nail care, including frequency of resident nail care, staff responsible for nail care and risks associated with nail care, such as diabetes or anticoagulant use. Ambulation: R56 was not ambulated as directed by physical therapy after he was discharged from therapy. On 10/23/13, R56 was observed and the following was noted: - At 7:55 a.m. NA-A and NA-B were observed to assist R56 stand with a transfer belt and walker. During transfer NA-A cued R56 to turn to his right side as NA-B guided R56's arm to the wheelchair arm rest. During transfer R56 stood, had short, shuffling steps and walked approximately 5 feet then sat down in the wheelchair. -At 8:13 a.m. NA-B was observed propelling R56 in the wheelchair past the nursing station to the dining room. - At 2:10 p.m. NA-A stated she ambulated R56 from outside his room to the dining room before lunch but had not ambulated R56 back from the meal. R56's MDS dated 9/18/13, indicated R56 required extensive physical assist of one with bed mobility, toileting and transfers. In addition, the MDS did not have information on the resident's ability to transition from sit to stand, walk/ambulate in the room or corridor. The care plan dated 7/14/13, identified R56 with physical functioning and self-care deficit related to rhabdomyolysis, atrial fibrillation, glaucoma, anemia, hypertension, congestive heart failure and cardiomyopathy as evidenced by needing	F 311		

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F 311	Continued From page 37	F 311		

assist with ambulation, bed mobility, repositioning and range of motion. Care plan goal "will continue to ambulate with assist up to 50 feet." The care plan also directed assist of one with transfer belt and walker to ambulate and nurse to complete weekly ambulation progress notes on participation, distance and pain. The nursing assistant assignment sheet "Team 1 (Alpha)" directed the nursing assistant to ambulate resident with assist of one with transfer belt and walker.

During document review it was revealed R56 had received physical therapy from 7/13/13 to 9/17/13. The PT [physical therapy] -Therapist Progress & Discharge Summary dated 9/17/13, indicated R56 was discharged due to plateau in progress. Summary further indicated R56 had made significant progress overall including his ability to transfer with stand by assist of one with 50% cues compared to maximum assist of two in the initial evaluation. The PT -Therapist Progress & Discharge Summary also indicated "Pt [Patient] is on ambulation program with nursing staff to and from meals to maintain ability to ambulate ..."

On 10/23/13, at 1:06 p.m. RN-B stated 7/19/13, MDS was R56's admission MDS and during this time R56 was being treated for vascular wounds. On 8/7/13, MDS R56 was being treated with an antibiotic for cellulitis which had been changed. In addition, R56 was complaining of back pain and was asking for more assistance especially with bed mobility. But overall R56's ADLs had improved as R56 required limited assist from extensive on the previous MDS. RN-B further stated R56 remained extensive assist of one with transfer on both MDS and R56 had been discharged from therapy on 9/17/13.

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F 311	Continued From page 38 On 10/24/13, at 9:10 a.m. the physical therapist stated at the start R56 required maximum assist of two with parallel bars and was not able to do stairs and maximum assist with bed mobility. The physical therapist went on to state R56 had issues with pain to both posterior ankles at the beginning of therapy but had gotten better over time. The physical therapist went on to state at discharge R56 was walking 150 to 300 feet with stand by assist and with walker. The physical therapist also stated the pain was more related to the ulcers in the toes which were addressed. The physical therapist further stated during therapy R56 had been provided an open toed shoe (Darco shoe) for his right foot and his ambulation and transfer abilities had improved greatly during and through discharge from the program but the biggest barrier for resident was cognitive issues. On discharge from therapy The physical therapist had gave nursing a communication sheet to continue ambulating R56 to and from meals. The physical therapist finally stated that once a resident was discharged from therapy and recommendation is made to nursing therapy was not responsible and would not follow up unless concern arises. On 10/24/13, at 12:40 p.m. LPN-B stated there was a communication breakdown that R56 needed to be ambulated per recommendation made upon discharge from therapy, when R56 was transferred from 1 West to 2 East. LPN-B went on to state that when R56 transferred to unit he had noted on the 2 East nursing assistant assignment sheets R56 was ambulating and on 10/1813, LPN-B had ambulated the resident 100 feet to see his ability. Additionally LPN-B verified there was no documentation of R56 ambulating	F 311		

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from 9/17/13 until 10/18/13. LPN-B stated he would take responsibility for not ensuring the ambulation program recommended by PT was implemented upon transfer to 2 East on 9/26/13.

On 10/24/13, at 2:11 p.m. the DON stated she was not sure about the communication between therapy and nursing about recommending therapy as she had been to therapy but therapy was not able to provide a copy the recommendation communication note when resident was discharged from therapy. She further stated that staff including the registered nurse in charge of the unit where resident had resided prior was not sure if that had been communicated to them either.

On 10/25/13, at 7:25 a.m. the Transitional Care Unit (TCU)/1 West manager RN-A stated R56 has used a lift to transfer on admission to TCU, towards the end of his stay in TCU he had changed to assist of 1 with transfer. She stated "I knew he was walking with PT but I could not remember if he was walking with nursing. RN-A further stated "if someone were ambulating, it would be on the team sheet; normally if physical therapy was completed and resident was supposed to be ambulated it would be put on the TAR." RN-A further stated she did not have a copy of the team sheet from when R56 was at TCU to look back if R56 had been on a walking problem as R56 remained in TCU for 9 days prior to being moved to 2 East.
-At 7:35 a.m. NA-D remembered R56 from room 114. He was still an EZ stand lift when she last cared for him. "I would set him up so he could brush his teeth, get his pants on and then lift him with the EZ stand to wash the peri-area.
-At 7:40 a.m. NA-E stated R56 transferred with

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F 311	Continued From page 40 mechanical stand, he was independent with eating. Did not ambulate with R56 or see him ambulate. Team sheet said assist of one; he was able to ask for help. -At 7:45 a.m. LPN-D remembered R56 needed wound care on his left leg, right lower leg and left abdomen/hip area, and he had seen R56 walking with therapy to the nursing station. -At 7:50 a.m. requested PT to ambulate with R56 and evaluate his ambulation ability. -At 7:55 a.m. RN-C stated she remembered giving R56 pills and wound cares/dressing changes and never saw him ambulate. On 10/25/13, at 8:01 a.m. RN-A again stated "Usually when a resident transferred to another unit, social service moved the belongings, the nurse moved the medications, the chart and reported to the floor nurse. The clinical manager (CM) reported to the clinical manager of the receiving unit to relay the team sheet information." RN-A vaguely remembered R56's transfer and believed she gave a verbal report to LPN-B. RN-A further stated she used the Point Click Care (PCC) Kardex to report if assistance was needed and basically everything on the team sheet was reported. RN-A went on to state "If the CM wasn't there I would leave it (the PCC Kardex) on his desk." On 10/25/13, at 8:10 a.m. the physical therapist observed apply the transfer belt, cued R56 to stand, when R56 stood he reported pain to the physical therapist and the pain was to both his legs. R56 then started walking with the physical therapist holding the transfer belt at the back. R56 took one rest break by the fire door at the nursing station but walked all the way to the dining room. After R56 was safely seated in the	F 311		

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F 311	Continued From page 41 dining room the physical therapist estimated the distance walked as 150 feet, then walked off the distance and stated closer to 140 feet. The physical therapist further stated the ambulation was about normal for him, "it always took him awhile to get going, and he used to take 2-4 rest breaks." The physical therapist stated she did not feel there was a decline in ambulation. On 10/25/13, at 8:18 a.m. LPN-B stated cares provided to R56 included transfers with assist of one with transfer belt, working on wounds (vascular ulcers on left leg and right foot 2nd digit), and underlying osteomyelitis. "The goal was to get him back to assisted living." LPN-B did remember getting a verbal report from RN-A. LPN-B pulled up and printed the PCC Kardex for R56 which indicated ambulation with assist of one. LPN-B verified he had not updated the PCC Kardex after transfer. On 10/25/13, at 9:00 a.m. the director of physical therapy (DPT) stated therapy recommendation were written onto a blue or yellow sheet when transferring care to nursing after any resident had been discharged from therapy. DPT stated specifically for R56 there was no copy in the record of the recommendations as the copy may have been shredded when he transferred to 2 East by the physical therapy aide that comes in and thins out the book (three ring binder of recommendation given, or in progress) since he was no longer in TCU, "She must have thought R56 discharged because we did expect him to go home" DPT further stated the blue sheets are used when there are extensive issues, or when a new technique is being used, so that therapy would train the staff and get a signature from the clinical manager. The yellow sheet (Maintenance	F 311		

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F 311	Continued From page 42 ambulation Program) was used more for gait issues and was probably what was used for R56, does not have a place for a signature but thought the sheet should probably have that. DPT also stated therapy should probably keep a copy permanently, instead of shredding the recommendation sheets. DPT finished by stating "In my five years working at the here, human error would have resulted in someone forgetting to provide a transfer sheet, but in this case physical therapist had stated that she definitely had written one and gave it to nursing." DPT reviewed the PT discharge progress note and verified on discharge the physical therapist had recommended R56 to be ambulate to and from meals. On 10/25/13, at 9:25 a.m. the physical therapist stated when she completed a communication sheet she would put it in the CM mailbox or hand it to the CM in the hallway in passing. On 10/25/13, at 9:28 a.m. RN-A stated "The therapist will usually give it to me (in person) or if I 'm not here it goes to my mailbox in the mailroom, right across from my office." RN-A further stated she then uses it to update the team sheets if needed and places it in the communication (3-ring binder) at the desk and when the resident transfers to another unit she puts it at the front of the chart. RN-A clarified there was not place at the nursing unit to leave the document. On 10/25/13, at 9:34 a.m. the DON stated "The usual process for therapy to nursing transfer is the therapist fills out a form and generally gives it directly to the nurse manager. And the manager follows up and sets it up appropriately." She further stated "If a resident was ambulating to	F 311		

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F 311	Continued From page 43 meals I would expect it to be on the TAR, and the nurse needs to sign off but in some cases it may just go to the team sheet." She added "If it was range of motion it would go to the TAR. If ambulating in the corridor I would anticipate it on the care plan and team sheet." The DON the care plan for R56 failed to identify R56 was on an ambulation program as per therapy recommendation. The DON further stated she would expect to see the care plan, TAR, and team sheet filled out with matching information per therapy recommendation. She also verified LPN-B had not written the care plan as recommended by therapy. In addition, the DON stated a transfer from TCU to another nursing unit would include social service notifying every one of the transfer and physically moving their belongings. The nurse moves the medications and chart up and gives report to the receiving nurse. The CM gave each other report, to provide continuity of care. The facility Restorative Guideline policy revised 2013, lacked information on documenting, assessing, re-assessing and tracking of resident(s) progress when on a ambulation program and lacked tracking of therapy recommendations upon discharge for nursing to continue with ambulation to maintain abilities.	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	F 329 * The residents R 214 and R162 have appropriate diagnoses from the physician for the use of their psychotropic medications. Resident R214 has the appropriate target behavior monitoring in place to	12-4-13

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F 329	Continued From page 44 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure psychotropic medications had appropriate physician's justification for use for 2 of 5 residents (R214, R162) reviewed for unnecessary mediations. In addition, the facility failed to ensure 1 of 5 residents (R214) had target behavior monitoring to determine the efficacy of the Seroquel (an antipsychotic medication). Findings include: R214 was observed on 10/22/13, at 10:45 a.m. sitting in a wheel chair actively participating in a social activity program. Record review revealed a Clinical Pharmacist	F 329	determine the efficacy of the antipsychotic medication. * All residents receiving psychotropic medications will have the appropriate diagnosis in place for the use of the medication. All residents receiving antipsychotic medications will have the appropriate target behaviors in place to evaluate the efficacy of the medication. * The Clinical Managers and the Licensed Social Workers have been educated on the requirement to obtain from the physician the appropriate diagnosis for the use of psychotropic medications and the requirement to put in place target behavior monitoring for all residents receiving antipsychotic medications. * Monitoring to ensure compliance will be conducted through random chart audits of residents receiving psychotropic medications to ensure the appropriate diagnosis for use is in place. Random chart audits will also be conducted for residents receiving antipsychotic medications to ensure appropriate target behavior monitoring is in place. * The facility QAPI committee will review the	

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F 329	Continued From page 45	F 329	results of the audits for psychotropic medication diagnoses and antipsychotic target behavior monitoring quarterly for further recommendations.	
			* The date of completion will be 12-4-13.	

Letter to Physician Services, dated 8/20/13 (only one day after admission), with recommendation "Please consider dose reduction to Seroquel 12.5 mg po [by mouth] with the goal of discontinuation", signed by the physician on 8/23/13, indicating recommendation accepted, 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.

The admission Minimum Data Set (MDS) dated 8/30/13, noted R214 have not any behaviors such as delirium, hallucinations, disorganized thinking, altered level of consciousness, or any other behaviors such as verbal, physical behavioral symptoms directed towards others. The MDS noted with diagnosis including Alzheimer's disease and dementia without behavioral disturbances.

The admission Care Area Assessment (CAA) dated 8/30/13, indicated "resident displays behaviors r/t [due to] Alzheimer's and receives medication to manage and treat condition." The CAA did not indicate what kind of behaviors R214 had.

R214's current electronic Physician's Orders indicated: "SEROguel tablet Give 25 mg [milligram] by mouth two times a day [BID] for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 46	F 329		

ANTIPSYCHOTIC" with 8/30/13, start date.

The Psychologist Progress Notes dated 9/3/13, and 9/30/13, indicated R214 had Alzheimer's and Adjustment Disorder with Anxiety, however did not identify diagnoses for Seroquel use.

Review of the Medication Regimen Review Summary revealed the consultant pharmacist reviewed R214's medications on 9/17/13, and 10/16/13. The pharmacist did not identify the lack appropriate physician indication/ diagnoses for the Seroquel use, and the lack of target behavior monitoring for September 2013 or October 2013.

R214's care plan dated 9/19/13, was reviewed. The care plan lacked indication of the Seroquel use, and there were no non-pharmacological interventions identified.

The Physician Progress Notes dated 10/4/13, 9/12/13, and 8/23/13, were reviewed, noted R214 had Dementia, unspecified, without behavioral disturbances.

The Daily Behavior observation for August 2013 identified three target behaviors: 1. persistent anger, 2. believes family/ people are waiting for him down stairs, 3. verbal aggression. There were no target behaviors monitored for September 2013 or October 2013.

The registered nurse (RN)-C/clinical manager was interviewed on 10/24/13, at around 1:10 p.m. The RN-C reviewed R214's record and confirmed there were no physician justification/appropriate diagnoses for the Seroquel use, the lack of care planning of the psychotropic medication (Seroquel) use, and the lack of target behavior

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	245293	A. BUILDING ______ B. WING ______	10/25/13 per GD ~~10/24/2013~~

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GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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monitoring for September and October.

The director of nursing (DON) was interviewed on 10/25/13, at 9:30 a.m. and explained there had to be physician documented diagnoses/clinical indication identified to justify the psychotropic medication use. The DON also explained it was the facility's expectation the pharmacist to identify irregularities such as: lack of appropriate diagnoses, lack of target behavior monitoring, and write appropriate recommendations.

The Behavior Management Guideline policy revised 2013, noted "Antipsychotic drugs should not be used unless the clinical record documents one or more of the following 'specific conditions', as dictated and documented by the Physician." The policy listed 11 diagnoses, including 11. "Organic mental syndromes (now called delirium, dementia, and amnesic and other cognitive disorders by DSM-IV) with associated psychotic and/ or agitated behaviors". The policy also noted "Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used: in excessive dose, for excessive duration, without adequate monitoring, without adequate indication for it's use, in the presence of adverse consequences which indicates the dose should be reduced or discontinued, any combination of the above reasons."

R162 was observed on 10/21/13, at 3:58 p.m. returning from the lobby with a cup of coffee. On 10/23/13, at 9:30 a.m. R162 was returning from participating in physical therapy.

The admission MDS dated 10/7/13, noted

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GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH HOPKINS, MN 55343**

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F 329	Continued From page 48 admission diagnosis of psychosis, dementia without behavioral disturbances, delusional disorder, Parkinson's disease, and need for rehab therapies. R162's Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognitive status and did not indicate any behaviors such as delirium, hallucinations, disorganized thinking, or any other behaviors such as verbal or physical symptoms directed towards others. R162's current Physician's Orders dated 10/7/13, indicated: "Depakote extended release (an anti-seizure medication that can be used for bipolar disorder) 500 mg every day for memory problem; Trazodone (a sedating antidepressant medication) 50 mg at bedtime for difficulty falling or staying asleep as needed; and Zyprexa (an antipsychotic medication that can be used for schizophrenia or bipolar disorder) 5 mg at bedtime for difficult falling or staying asleep. The Clinical Pharmacist Letter to Physician Services dated 10/8/13, indicated Zyprexa was not indicated for the treatment of sleep and actually has a black box warning for the use in Alzheimer's patients due to increased risk of mortality. The letter recommended " Please review the diagnosis for use of this antipsychotic. If none of the above (list of appropriate diagnosis for Zyprexa) apply. Please consider a dose reduction to Zyprexa 2.5 mg by mouth at bedtime for 2 weeks, then discontinue." On 10/9/13, the physician selected rejected but did not provide supporting documentation. The Pharmacist did not identify lack of appropriate diagnosis for Depakote. The admission CAA dated 10/16/13, did not	F 329		

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trigger for or delirium or cognitive loss/dementia, but did indicate psychotropic drug use for behaviors in the history and physical (unidentified). The CAAs lacked evidence of any documentation of R162's behaviors.

The Physician Progress Notes dated 10/29/13, were reviewed and indicated dementia vascular versus Alzheimer's on Depakote, but did not indicate any behaviors. The medical record lacked evidence of additional progress notes or psychiatric notes which would indicate an appropriate diagnosis for Depakote and an appropriate indication for Zyprexa.

A review of the Medication Administration Report dated October 2013, indicated Zyprexa and Depakote had been given daily, but Trazodone as needed had not been given to R162 for difficulty falling or staying asleep (appropriate indication).

The Daily Behavior Observation for October 2013, identified two target behaviors for Zyprexa: 1. Paranoid statement 2. Delusions (psychosis). One target behavior was identified for Trazodone: 1. Insomnia. There was no behavior monitoring sheets for the use of Depakote. Zero behaviors were documented for any medication. The facility documented a sleep study for seven nights from 10/6/13 through 10/11/13, which did not provide hours of sleep.

A review of the Medication Regiment Review Summary revealed the consultant pharmacist reviewed R162's medications on 10/7/13 and only recommended an appropriate indication for the Zyprexa and not the Depakote.

R162's care plan dated 10/5/13 and 10/21/13,

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F 329	Continued From page 50 was reviewed and indicated R162 received Trazodone for insomnia, although R162 had not received Trazodone in the facility. A care plan dated 10/4/13 indicated behaviors which include paranoid statements, delusions, psychosis, and use of Zyprexa to manage those behaviors which included non-pharmacological interventions, however no behaviors were recorded and the Zyprexa was ordered for inability to fall asleep and stay asleep (not an appropriate indication). A care plan dated 10/21/13, for potential for drug related complications associated with psychotropic medications, although the medication lacked appropriate indications for use. On 10/23/13, at 10:00 a.m. the DON and registered nurse-clinical manager (RN)-A of 1 West TCU) explained the doctor clarification was requested for Zyprexa, because insomnia was not an indication, and also stated Depakote was listed for Alzheimer's on the Clinical Pharmacist Medication Regiment Review Summary. However, the consultant pharmacist did not request a clarification for indication for Depakote on the letter of recommendation to the physician. On 10/24/13 at 12:33 p.m. the consultant pharmacist was interviewed regarding unnecessary medications and stated Zyprexa was not indicated for sleep and " I wrote the recommendation to provide appropriate indication. " The clinical pharmacist further stated that although she had written Depakote for Alzheimer's on the Medication Regimen Review Summary, she had not requested a clarification of diagnosis from the physician. The Behavior Management Guideline policy revised 2013, noted "Antipsychotic drugs should	F 329		

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F 329	Continued From page 51 not be used unless the clinical record documents one or more of the following 'specific conditions', as dictated and documented by the Physician." The policy listed 11 diagnoses, including 11. "Organic mental syndromes (now called delirium, dementia, and amnesic and other cognitive disorders by DSM-IV) with associated psychotic and/ or agitated behaviors". The policy also noted "Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used: in excessive dose, for excessive duration, without adequate monitoring, without adequate indication for it's use, in the presence of adverse consequences which indicates the dose should be reduced or discontinued, any combination of the above reasons."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consulting pharmacist failed to identify and report irregularities concerning the lack of physician documented clinical indication and the	F 428	F 428 * The resident R214 has documented physician clinical indication for the use of the antipsychotic medication and has the appropriate target behavior monitoring in place for the use of the antipsychotic medication. * The facility consulting pharmacist will review all resident drug regimens monthly and will report the lack of appropriate clinical indications for psychotropic medication use and will report the absence of target behavior monitoring for residents receiving antipsychotic medications to	12-4-13

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F 428	Continued From page 52 lack of target behavior monitoring to determine the efficacy of the Seroquel (an antipsychotic medication) for 1 of 5 residents (R214) reviewed for unnecessary medications. Findings include: R214 was observed on 10/22/13, at 10:45 a.m. sitting in a wheel chair actively participating in a social activity program. R214's Admission Record indicated R214 was admitted to the facility on 8/19/13, with diagnosis including Alzheimer's disease and dementia without behavioral disturbances. Further record review revealed a Clinical Pharmacist Letter to Physician Services, dated 8/20/13 (only one day after admission), with recommendation "Please consider dose reduction to Seroquel 12.5 mg po [by mouth] with the goal of discontinuation", signed by the physician on 8/23/13, indicating recommendation accepted, and on 8/26/13, the Seroquel dose was reduced to 12.5 mg po BID. The pharmacist did not identify lack of appropriate diagnoses. 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. The admission Minimum Data Set (MDS) dated 8/30/13, noted R214 have not any behaviors such as delirium, hallucinations, disorganized thinking, altered level of consciousness, or any other	F 428	the attending physician and DNS. * The consulting pharmacist has been educated and is aware of the requirements to report lack of indication for the use of antipsychotic medications and the lack of appropriate target behavior monitoring for those residents receiving antipsychotic medications to the physician and the DNS. * Monitoring to ensure compliance will be conducted through random audits of the consulting pharmacist's recommendation summary reports for recommendations required for medication clinical indications for use and recommendations for appropriate target behaviors. * The facility QAPI committee will review the results of the pharmacy audits quarterly for further recommendations. * The date of completions is 12-4-13.	

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F 428	Continued From page 53 behaviors such as verbal, physical behavioral symptoms directed towards others. The admission Care Area Assessment (CAA) dated 8/30/13, indicated "resident displays behaviors r/t [due to] Alzheimer's and receives medication to manage and treat condition." the CAA did not indicate what kind of behaviors R214 had. The current electronic Physician's Orders indicated: "SEROguel tablet Give 25 mg [milligram] by mouth two times a day [BID] for ANTIPSYCHOTIC" with 8/30/13, start date. The Psychologist Progress Notes dated 9/3/13 and 9/30/13, indicated R214 had Alzheimer's and adjustment disorder with anxiety, however, did not identify diagnoses for Seroquel use. Review of the Medication Regimen Review Summary revealed the consultant pharmacist reviewed R214's medications on 9/17/13, and 10/16/13. The pharmacist did not identify the lack appropriate physician indication/diagnoses for the Seroquel use, and the lack of target behavior monitoring for September 2013 or October 2013. R214's care plan dated 9/19/13, was reviewed. The care plan lacked indication of the Seroquel use, and there were no non-pharmacological interventions identified. The Physician Progress Notes dated 10/4/13, 9/12/13, and 8/23/13, were reviewed, noted R214 had Dementia, unspecified, without behavioral disturbances. The Daily Behavior observation for August 2013	F 428		

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F 428	Continued From page 54 identified three target behaviors: 1. persistent anger, 2. believes family/ people are waiting for him down stairs, 3. verbal aggression. There were no target behaviors monitored for September 2013 or October 2013. The registered nurse (RN)-C/clinical manager was interviewed on 10/24/13, at around 1:10 p.m. The RN-C reviewed R214's record and confirmed there were no physician justification/appropriate diagnoses for the Seroquel use, the lack of care planning of the psychotropic medication (Seroquel) use, and the lack of target behavior monitoring for September 2013 and October 2013. The registered pharmacist (RP) was interviewed on 10/24/13, at 1:37 p.m. and verified she have reviewed R214's medication regimen on 9/17/13, and 10/16/13. The RP stated she could not remember if she had reviewed R214's target behaviors, and was not aware there was no target behavior monitoring for September 2013 and October 2013. After reviewing the record the RP acknowledged the physician should have been updated about R214's behaviors to write appropriate diagnoses for the use of the Seroquel. The director of nursing (DON) was interviewed on 10/25/13, at 9:30 a.m. and explained there had to be physician documented diagnoses/clinical indication identified to justify the psychotropic medication use. The DON also explained it was the facility's expectation the pharmacist to identify irregularities such as: lack of appropriate diagnoses, lack of target behavior monitoring, and write appropriate recommendations.	F 428		

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F 428	Continued From page 55 The Behavior Management Guideline policy revised 2013, noted "Antipsychotic drugs should not be used unless the clinical record documents one or more of the following 'specific conditions', as dictated and documented by the Physician." The policy listed 11 diagnoses, including 11. "Organic mental syndromes (now called delirium, dementia, and amnesic and other cognitive disorders by DSM-IV) with associated psychotic and/ or agitated behaviors." The policy also noted "Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used: in excessive dose, for excessive duration, without adequate monitoring, without adequate indication for it's use, in the presence of adverse consequences which indicates the dose should be reduced or discontinued, any combination of the above reasons."	F 428	Annual Room Size Wavier	
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 22 of 22 resident bedrooms met the required room size of at least 80 square feet for a single resident rooms and 120 square feet for a double room. Findings include: During the entrance conference on 10/21/13, at	F 458	F 458 * Golden Living Center Hopkins would like to request a waiver under F458 in regards to resident room size. The specific rooms to be included in this waiver are: 140,141, 142,143,144,146,163,165,167,169,171,173,175,222,224,240,258,260,262,264,269,271, and 277. * These rooms were constructed in 1955 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the	~~12-4-13~~

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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 458	rooms without causing hardship on the facility. * Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The resident's health, treatments, comfort, safety, and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. * The Executive Director is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	

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F5293022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	10/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on October 28, 2013. At the time of this survey, Golden LivingCenter Hopkins was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	POC ok FB 11-29-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly A. Y — TITLE: Interim Executive Director — (X6) DATE: 11/21/13

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

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	245293	A. BUILDING **02 - 2008 ADDITION** B. WING	**10/28/2013**

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Hopkins Therapy building 2 was constructed in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. Because the original building and the five (5) additions meet the construction type allowed for both new and existing health care occupancies, the facility was surveyed as 1-building and two (2) Form CMS-2786R booklets were completed; Building 01 in accordance with Chapter 19 Existing Health Care Occupancies and Building 02 in accordance with Chapter 18 New Health Care Occupancies. The facility has a capacity of 138 beds and had a census of 120 at the time of the survey.	K 000		

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K 046	Continued From page 2	K 046		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based on documentation review and an interview with staff, the facility has failed to ensure that emergency lighting has been maintained and tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect all residents, staff and visitors in the event of a loss of power and generator failure. . Findings include: On facility tour between 12:30 PM and 3:30 PM on 10/28/13, during documentation review and an interview with the Maintenance Supervisor, it was revealed that there was no documentation of monthly 30 second testing, and the annual 1 1/2 hour testing for the battery powered emergency light above the generator.	K 046	K 46 * The testing of the battery operated emergency light at the generator has been 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. * The maintenance staff have been trained on the regulation requiring monthly and annual testing of the battery operated emergency light. * Monitoring to ensure compliance will be conducted by the Maintenance Director or Designee through audits to 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.	12-4-13

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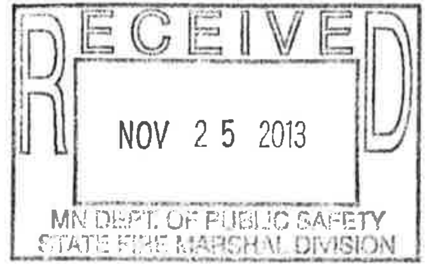
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on October 28,2013. At the time of this survey, Golden LivingCenter Hopkins was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	POC ok TB 11-29-13	

Dc: 12-4-13
Exit: 10-28-13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Interim Executive Director (X6) DATE: 11/21/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Hopkins was constructed as follows: The original building was built in 1958, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 1st Addition was built in 1960, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 2nd Addition was built in 1965, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 3rd Addition was built in 1989, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 4th Addition was built in 1993, is two-stories, has no basement is fully fire sprinkler protected and is of Type II(222) construction; The most recent addition was constructed in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(222)	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING ___	10/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. Because the original building and the five (5) additions meet the construction type allowed for both new and existing health care occupancies, the facility was surveyed as 1-building and two (2) Form CMS-2786R booklets were completed; Building 01 in accordance with Chapter 19 Existing Health Care Occupancies and Building 02 in accordance with Chapter 18 New Health Care Occupancies. The facility has a capacity of 138 beds and had a census of 120 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on documentation review and an interview with staff, the facility has failed to ensure that emergency lighting has been maintained and tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect all residents, staff and visitors in the event of a loss of power and generator failure. . Findings include:	K 046	K 46 * The testing of the battery operated emergency light at the generator has been 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. * The maintenance staff have been trained on the regulation requiring monthly and annual testing of the battery operated emergency light.	12-4-13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/28/2013**

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GOLDEN LIVINGCENTER - HOPKINS	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

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K 046	Continued From page 3 On facility tour between 12:30 PM and 3:30 PM on 10/28/13, during documentation review and an interview with the Maintenance Supervisor, it was revealed that there was no documentation of monthly 30 second testing, and the annual 1 1/2 hour testing for the battery powered emergency light above the generator.	K 046	* Monitoring to ensure compliance will be conducted by the Maintenance Director or Designee through audits to 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.	