Michelle Koch, HFE NE II

CENTERS FOR

Kate JohnsTon, Program Specialist

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

K	MEDICARE & MEDIC	AID SERVICES
	ID:	LRZ7
	Fac	eility ID: 00112
	4. TYPE OF ACTION:	7 (L8)
	1. Initial	2. Recertification
	3. Termination	4. CHOW
	5. Validation	6. Complaint
	7. On-Site Visit	9. Other
	8. Full Survey After Comp	plaint
	FISCAL YEAR ENDING D	ATE: (L35)
	12/31	
The	Following Requirements:	es Limit

05/11/2016

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN VALLEY REHABILITATION AND CARE CENTER (L1) (L4) 7505 COUNTRY CLUB DRIVE 2.STATE VENDOR OR MEDICAID NO. 254908000 (L6) 55427 (L2) (L5) GOLDEN VALLEY, MN 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) (L9) 07/01/2015 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 04/27/2016 02 SNF/NF/Dual 06 PRTF 6. DATE OF SURVEY (L34) 10 NF 14 CORF 8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of T From (a): Program Requirements ___ 2. Technical Personnel То (b): Compliance Based On: ____ 3. 24 Hour RN ___ 4. 7-Day RN (Rural SN _1. Acceptable POC 12. Total Facility Beds 164 (L18) ___ 5. Life Safety Code 164 (L17) 13. Total Certified Beds B. Not in Compliance with Program Requirements and/or Applied Waivers: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): 19 SNF 164 (L38) (L37) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date:

		(=)		(L20)
	PART II - TO BE COM	PLETED BY HCFA REGIONA	AL OFFICE OR SINGLE STATE AGE	NCY
DETERMINATION OF ELIGIBILE 1. Facility is Eligible to F 2. Facility is not Eligible	rarticipate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. I. Statement of Financial Solven 2. Ownership/Control Interest D 3. Both of the Above : ———————————————————————————————————	
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 08/31/1973	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTION A. Suspension of Admission		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	B. Rescind Suspension Dat	(L44) e:		00-Active
		(L45)		
28. TERMINATION DATE:	29. INTERM	EDIARY/CARRIER NO.	30. REMARKS	
	063	01		
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERM	NATION OF APPROVAL DATE		
	(L32)	016 (L33)	DETERMINATION APPROVAL	

04/27/2016



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245186 May 12, 2016

Ms. Lynn Hickey, Administrator Golden Valley Rehabilitation & Care Center 7505 Country Club Drive Golden Valley, Minnesota 55427

Dear Ms. Hickey:

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 April 12, 2016 the above facility is certified for or recommended for:

164 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 164 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Golden Valley Rehabilitation And Care Center May 12, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 12, 2016

Ms. Lynn Hickey, Administrator Golden Valley Rehabilitation & Care Center 7505 Country Club Drive Golden Valley, Minnesota 55427

RE: Project Number S5186030

Dear Ms. Hickey:

On March 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 12, 2016 and therefore remedies outlined in our letter to you dated March 21, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Golden Valley Rehabilitation And Care Center May 12, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
245186 _{Y1}	B. Wing	Y2	4/27/2016	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN VALLEY REHABILITATION	ON AND CARE CENTER	7505 COUNTRY CLUB DRIVE				
		GOLDEN VALLEY, MN 55427				

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

ITE	M		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0282		Correction	ID Prefix	F0309		Correction	ID Prefix	F0311		Correction
Reg. #	483.20(k)(3)(ii)		Completed	Reg. #	483.25		Completed	Reg. #	483.25(a)(2)		Completed
LSC			04/12/2016	LSC			04/12/2016	LSC			04/12/2016
ID Prefix	F0312		Correction	ID Prefix	F0314		Correction	ID Prefix	F0315		Correction
Reg. #	483.25(a)(3)		Completed	Reg.#	483.25(c)	Completed	Reg. #	483.25(d)		Completed
LSC			04/12/2016	LSC			04/12/2016	LSC			04/12/2016
ID Prefix	F0329		Correction	ID Prefix	F0332		Correction	ID Prefix	F0353		Correction
Reg. #	483.25(I)		Completed	Reg.#	483.25(m)(1)	Completed	Reg.#	483.30(a)		Completed
LSC			04/12/2016	LSC			04/12/2016	LSC			04/12/2016
ID Prefix	F0364		Correction	ID Prefix	F0371		Correction	ID Prefix	F0412		Correction
Reg.#	483.35(d)(1)-(2)		Completed	Reg.#	483.35(i)	Completed	Reg. #	483.55(b)		Completed
LSC			04/12/2016	LSC			04/12/2016	LSC			04/12/2016
ID Prefix	F0425		Correction	ID Prefix	F0428		Correction	ID Prefix	F0431		Correction
Reg. #	483.60(a),(b)		Completed	Reg.#	483.60(c)	Completed	Reg. #	483.60(b), (d), (e)		Completed
LSC			04/12/2016	LSC			04/12/2016	LSC			04/12/2016
REVIEWE STATE AG		REVIEWE (INITIALS		DATE 05/12/2	2016	SIGNATURE OF SI		5575		DATE 04/2	27/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER A. Building 245186 Y1 B. Wing				FRUCTION				Y2	DATE OF REVISIT 4/27/2016 _{Y3}		
NAME OF			DN AND CARE C	ENTER		STREET ADDRESS, CI 7505 COUNTRY CLUB GOLDEN VALLEY, MN	DRIVE	12	13		
program, corrected provision	to show those of	eficiencie ich correc	s previously reportive action was ac	rted on the CMS-25 ccomplished. Each	667, Staten deficiency	and/or Clinical Laboration of Deficiencies and should be fully identification (prefix codes should be fully identification).	d Plan of Correction, led using either the re	that have egulation or	LSC		
ITE	M		DATE	ITEM	DATE ITEM				DATE		
Y4			Y5	Y4		Y5	Y4		Y5		
ID Prefix	F0465		Correction								
Reg.#	483.70(h)		Completed								
LSC			04/12/2016								
REVIEWE STATE AG		REVIEW (INITIAL	S) JS/KJ	DATE 05/12/2016	SIGNATUR	RE OF SURVEYOR	5575		DATE 04/27/2016		
REVIEWE CMS RO	D BY	REVIEW (INITIAL	ED BY	DATE	TITLE				DATE		
FOLLOW (3/3/2016	JP TO SURVEY C	OMPLETE	D ON	_	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		ICARE/MEDICA I - TO BE COM						ID: LRZ7 Facility ID: 00112
MEDICARE/MEDICAID PROVIDER (L1) 245186 2.STATE VENDOR OR MEDICAID NO (L2) 254908000 5. EFFECTIVE DATE CHANGE OF OVER		3. NAME AND ADI (L3) GOLDEN VA (L4) 7505 COUNT (L5) GOLDEN VA 7. PROVIDER/SUF	ALLEY REHABII CRY CLUB DRIV ALLEY, MN	LITATION E	(Le	CENTER (6) 55427	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation 7. On-Site Visit	
(L9) 07/01/2015		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey Afte	r Complaint
	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDI	NG DATE: (L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:					
From (a): To (b):		A. In Compliar Program Rec Compliance	quirements Based On:		2. To	echnical Personnel 4 Hour RN	e Following Requirements: 6. Scope of S 7. Medical D	Services Limit
12.Total Facility Beds	164 (L18)	1. A	cceptable POC			-Day RN (Rural SNF)		
13. Total Certified Beds	164 (L17)	1	pliance with Program and/or Applied Waive		5. Li * Code:	ife Safety Code B*	9. Beds/Room (L12)	n
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY	Y MEETS		
18 SNF 18/19 SNF 164	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR 17. SURVEYOR SIGNATURE Mardelle Trett		Date :	04/11/2016			JRVEY AGENCY AF		Date:
Wiardene freu	ei, fife ne i	<u>1</u>	04/11/2010	(L19)	<u>Kate Jo</u>	ohns I on, Pr	rogram Specia	04/11/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OF	R SINGLE STAT	TE AGENCY	
DETERMINATION OF ELIGIBILIT	articipate		IPLIANCE WITH CI ITS ACT:	VIL	2		cial Solvency (HCFA-2572) Interest Disclosure Stmt (H	CFA-1513)
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERMIN	NATION ACTION:		(L30)
OF PARTICIPATION 08/31/1973	BEGINNING I	DATE	ENDING DATE	;	VOLUNTARY 01-Merger, Clo		_	UNTARY o Meet Health/Safety
(L24)	(L41)		(L25)			tion W/ Reimburseme	ent 06-Fail to	o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE	E SANCTIONS				oluntary Termination	OTHER	
	A. Suspension of	of Admissions:			04-Other Reaso	on for Withdrawal		der Status Change
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)				00-Activ	e
00 mph m / m / m / m		Dimens con-			20 222			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	AKRIER NO.		30. REMARK	.S		
	(L28)	06301		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	E	Posted	04/26/2016	Co.	

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 21, 2016

Ms. Lynn Hickey, Administrator Golden Valley Rehabilitation & Care Center 7505 Country Club Drive Golden Valley, Minnesota 55427

RE: Project Number S5186030

Dear Ms. Hickey:

On March 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5186212 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor Minnesota Department of Health St. Cloud B Survey Team Licensing & Certification Health Regulation Division Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343

Fax: (320)223-7348

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 April 12, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 3, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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.

Feel free to contact me if you have questions.

Golden Valley Rehabilitation & Care Center March 21, 2016 Page 6

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 04/11/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION (7	X3) DATE SURVEY COMPLETED
		245186	B. WING		03/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENT	ΓS	F 000		
F 282 SS=D	as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electron be used as verificat Upon receipt of an acconsite revisit of you validate that substate regulations has been your verification. A complaint investign the time of the stand H5186212, and was 483.20(k)(3)(ii) SEFPERSONS/PER CATTHE SERVICES provided by accordance with eacare. This REQUIREMENT by: Based on observative review, the facility for care was implement residents (R89, R11).	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with gation was also completed at dard survey, complaint sunsubstantiated. RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of the consure the plan of sted and followed for 2 of 3 l.5, R5) reviewed for pressure esidents (R5) dependent upon	F 282	1.R89,R5,R60's skin assessments, of care, and nursing assistant care g have been reviewed and updated as appropriate. R115 is not longer a res at the facility. 2.All residents with pressure ulcers v assessed and plan of care and nursi assistant care guides reviewed and	uides sident vill be
	R89's plan of care of	dated 6/15, noted R89 was to		updated as indicated. 3.Nurses will be educated on	
ABORATOR\	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE	(X6) DATE

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

TITLE

Electronically Signed

04/01/2016

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245186	B. WING			03/0	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	have both heels float noted R89 was to he foot when in bed. The undated and undid not specify R89 nor did the sheet in foam boot on the rigskin noted staff wer checks. Assist resid [as needed]." R89 was observed through 7:29 a.m. obe sleeping on his ladirectly on the mattifoam boot on it. At (NA)-A was intervie have the heels float should have been for Registered nurse or interviewed at 8:00 have the heels float a newly formed blis intact. She indicated the right heel as the verified the NA sheef oam boot and to floot The health unit coo observed on 3/2/16 computerized NA side information of the heels was not on the R89 did not receive promoted healthy sides.	ated. In addition, the care plan ave the "bootie" on the right ntitled NA assignment sheet was to have the heels floated dicate R89 was to wear a ght foot. The section under the to "Q [every] shift skin dent with back scratcher PRN on 3/2/16, at 6:20 a.m. continuously. R89 was noted to back and both heels were lying tress. The right heel had a blue 7:29 a.m. nursing assistant wed and verified R89 did not ted. When asked if the heels loated NA-A indicated, "No." onsultant (RNC)-A was a.m. and verified R89 did not ted. RNC-A indicated R89 had ter on the right foot and it was defended the blue boot and floating the ecomputerized NA sheet. HUC-A acknowledged the blue boot and floating the ecomputerized NA sheet. It the care and services that	F 2	82	implementing and following wound protocol for residents with pressure ulcers, including completing and documenting treatments. Nursing will be educated on following interversion for pressure ulcer prevention and residents with pressure ulcers, including/repositioning and using preservelieving devices or techniques. 4.DON or designee will complete reweekly audits to ensure staff follow plan of care for residents at risk for altercation, including toileting and repositioning, for 4 weeks. Results audits will be reviewed at QAPI for tracking and trending. QAPI team wadjust audit schedule accordingly to trending identified.	staff entions uding ssure andom s the skin of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		245186	B. WING		03/	03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	identified a well der and implements and based on the asses Pressure Ulcer Tree Physician Orders On 3/2/16, at 8:41 R115 pressure ulcer had two ulcers one was beefy red, with showed no signs or practitioner stated R115's Skin Integri Treatment Care Pland a pressure ulcer to the provide treatment gressure ulcer to the provide treatment gressure wound directed staff to one skin prep and cover lll pressure wound medial buttock follows the wounds. The February 2016 treatment to cleans skin prep and covereviewed. 7 days in left blank and 4 day. When interviewed stated R115 is supply change to the sacrification the wound physicial wednesday. RN-G is not always done.	veloped care plan develops interdisciplinary care plan assment information gathered. atment Not Completed per a.m. with the nurse practitioner are were observed. The coccyx above the other wound bed nout drainage, odor and finfection. The nurse the ulcers were healing nicely. The ty Assessment: Prevention and an dated 1/16, indicated R115 are to midline sacrum and a ne coccyx and directed staff to	F 282			

-	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE					
		245186	B. WING		03/	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 282	treatment sheets in if not marked the treatment care Play reatment Care Play ressure ulcer to the staff to provide treatment care physician's orders once daily apply Sawith foam dressing the right ischium. On 3/3/16, at 9:27 a observation of pressure ulcer to the staff to provide treatment foam dressing the right ischium. On 3/3/16, at 9:27 a observation of pressure ulcer to cleans cover with non adhormation and documented as corone out of five days. The February 2016 treatment to cleans cover with adhesive of 28 days the treatment to cleans cover with	dicated resident refusals and eatments were not completed. Assessment: Prevention and an dated 1/16, indicated a le right ischium and directed the the theoretical than the per MD order. Cated 1/27/16, directed staff to antyl, apply skin prep and cover to Stage III pressure wound to a.m. R60 refused surveyor sure ulcer. Treatment record for the daily elevated and was reviewed. By the treatment was not an analyse and treat with Santyl and elevated and was blank and a marked as refused. Treatment record for the daily elevated and was reviewed. Nine out the foam was reviewed. Nine out the foam was reviewed. Nine out the foam was not documented as a blank. Seven out of 28 days elevated without any follow up one out of 28 days were	F 28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPL	
		245186	B. WING			03/	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	REET ADDRESS, CITY, STATE, ZIP CODE 15 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427	1 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	When interviewed of stated that R60 had her coccyx and it do ordered because the further stated she rethe dressing was not when interviewed of expected the wour ordered. RN- further nurses that at times get done on the shift nurses to pass it or stated that at times everything done.	on 3/3/16, at 3:38 p.m. RN-d wound care ordered daily to be not get done everyday as the facility is short staffed. RN-deports off to the next shift that bot completed. On 3/3/16, at 3:50 p.m. RN-d care be completed as the stated she has been told by a that the wound care did not fit. RN- stated she tells the to the next shift. RN- further staffing is not adequate to get on 3/3/16, at 5:43 p.m. RNC-A all treatments to be done	F 2	82			
	1/6/16, indicated the cognitive impairment for all activities of dalso identified diagramments hypertension, perip	num Data Set (MDS) dated e resident had severe nt, and was dependent on staff aily living (ADL's). The MDS noses of quadriplegia, heral vascular disease, and function of the bladder.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	identifies a risk of s mobility and bowel directed to turn, repincontinence every undated work list diposition R5 every to stool and was to be two hours. On 3/2/16, R5 was 6:21 a.m. to 8:28. A his back in bed with 7:06 a.m., respirato room to perform rescontinued to remain back, RT-A comple exited the room. Rowas not repositione during this time. At same backlying posassistant (NA)- B end the surveyor that rowere provided by the a.m., more than 2 h. The day shift staff volume as incontinent of a R5's skin had two labuttocks, near rectuarea of soft, white, covered with white pink underlying tiss an area of macerati that measured approximation of the covered with which in the work of the covered with white pink underlying tiss an area of macerati that measured approximation in width which	ge 5 e plan updated 1/15/16 kin breakdown with impaired incontinence. Staff were position, check and change for 2 hours. Review of the NA rects the staff to turn and wo hours, was incontinent of checked and changed every observed continuously from at at 6:21 a.m. R5 was lying on a pillow on the right side. At rry therapist (RT)-A entered spiratory cares. At 7:35 a.m., a in the same position on his ted the respiratory cares and 5 remained on his back, and d nor was peri care performed 8:18:a.m. R5 remained in the sition. At 8:28 a.m. nursing intered the room, and informed utine personal morning cares be night shift staff before 6:00 hours and 28 minutes earlier. Were responsible to provide R5 ontinence care prior to getting at the NA-B provided pericare, R5 a soft stool during this time. Barge areas on his right and left am that was macerated, (and deteriorating skin), which was barrier cream with areas of the exposed. There was also on under the right gluteal fold oximately 2 cm in length and a build up of sloughed the maceration, with bright	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		245186	B. WING		03/	03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=G	NA-B stated this ar and she would let to R5 was observed in a.m. seated in his whe continued to be a.m. NA-B and NA-with the mechanical was last provided with the mechanical was last provided with a man who was incontined. During interview or stated that she word different shifts and reposition him ever buttocks and to che every two hours. 483.25 PROVIDE CHIGHEST WELL B	sue present (skin was intact). rea (right gluteal fold) was new the nurses know. In his room, on 3/3/16, at 9:44 wheelchair (w/c). At 10:11 a.m. in the same position. At 10:16 r-A were assisting R5 into bed al lift. NA-B stated that (R5) with pericare this morning at 2 hours and 31 minutes JA-B provided pericare to R5, at of soft stool. In 3/3/16 at 5:10 p.m., NA-J, rks with R5 routinely on was aware to turn and by 2 hours, so he was off his eck for bowel incontinence	F 282			4/12/16
	provide the necess or maintain the high mental, and psychol accordance with the and plan of care.	ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment				
	Based on observa review, the facility f interventions to rec	tion, interview and document ailed to implement luce skin irritation and 2 residents (R5, R23)		1.R5 and R23 skin assessments, p care, and nursing assistant care gu have been reviewed and updated. R86 is no longer a resident at the f	ides	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/	03/2016	
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	This resulted in act moisture associate when interventions addition, the facility an outside dialysis (R86) reviewed for Findings include: NON PRESSURE R5's quarterly Minit 1/6/16, indicated the cognitive impairmed catheter, was alward dependent on staff (ADL's). The MDS quadriplegia, hyperdisease, and neurobladder. During interview or registered nurse (For moisture associated the left buttocks med 4.5 cm, and one or cm x 5 centimeters. On 3/2/16, R5 was 6:21 a.m. to 8:28 a on his back in bed At 7:06 a.m., respir room to perform re R5 continued to rein his back, RT-A con and exited the room and was not reposite.	ressure related skin conditions. tual harm for R5 whose d skin damage became worse were not implemented. In a failed to collaborate care with agency for 1 of 1 residents dialysis.	F 3	2.All residents with non pressiskin alterations will be assess care and nursing assistant careviewed and updated. All resreceiving dialysis services will to ensure collaboration/comm between dialysis and SNF. 3.Nurses will be educated on policies/procedures for reside alterations including assessing documentation, implementing interventions, and monitoring with skin alterations. They will educated on dialysis collaboration/communication. staff will be educated on follow interventions for preventing shalterations including reposition incontinence care. 4.DON or designee will complemented for residence pressure related skin breakdoweeks. DON or Designee will communication between SNF center weekly is being compleweeks. All audit results will be QAPI for tracking and trending team will then adjust audit schaccordingly to trending identification.	ed, plan of re guides idents be reviewed unication proper nts with sking & residents also be Nursing wing kin ning and lete random entions are nts with non own for 4 audit and dialysis eted for 4 reviewed at g. QAPI nedule		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
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F 309	a.m. nursing assis and informed the sign morning cares we staff before 6:00 a minutes earlier. The responsible to provincontinence care breakfast. NA-B princontinent of a so skin had two large buttocks, near recease of soft, white covered with white pink underlying tis an area of macera that measured approximates of dead tissue maceration, with be present (skin was	age 8 ame backlying position. At 8:28 tant (NA)- B entered the room, surveyor that routine personal are provided by the night shift .m., more than 2 hours and 28 are day shift staff were vide R5 assistance with prior to getting him up for provided pericare and R5 was areas on his right and left tum, that was macerated (an a deteriorating skin), which was a barrier cream and areas of sue exposed. There was also attion under the right gluteal fold broximately 2 cm in length and a build up of slough (a aue) to the side of the right pink underlying tissue intact). NA-B stated this area was new and she would let the	F 309			
	wound care medic RN-B to evaluate buttocks with the sassessed the area the macerated are associated dermal on the right glutea over the ischial tuk macerated. RN-B of the new area of until now. MD-A reprovide "careful ar	8 p.m. R5 was seen by the al doctor (MD)-A and the macerated areas on his surveyor present. MD-A on R5's buttocks and stated as were "incontinence it is with excoriations." The area of fold was an "old healed ulcer perosity" that was becoming stated that she was not aware maceration on the gluteal fold commended to RN-B to and meticulous hygiene" rier protection to these areas.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` /	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 309	stated R5's skin had to 6 and that incontral alkaline and can early stated that treatment incontinence associated that treatment incontinence associated that treatment incontinence associated and monitor. On 3/3/16, at 9:44 arrown seated in his along along the continued to 10:16 a.m. NA-B arrown seated with the mechal (R5) was last provided to all the mechal (R5) was last provided to the three maceral measured 8 cm x 6 and right gluteal for stated all three area increased in size frow taken on 2/21/16. Review of progress R5 had an open area the right buttocks mouttocks 7 x 4.5 cm "open does not look dressing changes." progress notes did measurements, or a R5's macerated skill Review of the physical 2/24/16, R5's primal stated and continued the physical stated and stated all three area increased in size frow the right buttocks mouttocks 7 x 4.5 cm "open does not look dressing changes." progress notes did measurements, or a R5's macerated skill Review of the physical stated and the physical stated a	int interview at 1:34 p.m., MD-A is an acid mantle of about 4.5 inence, especially stool, is sily excoriate the skin. MD-A not recommendations for itated dermatitis included in application of a barrier ring of the area. a.m. R5 was observed in his wheelchair (w/c). At 10:11 of be in the same position. At not NA-A were assisting R5 into unical lift. NA-B stated that died with pericare this morning (2 hours and 31 minutes NA-B provided pericare to R5, at of soft stool. RN-B, who was me, obtained measurements atted areas. The right buttock cm, left buttocks 9 cm x 6 cm and 2.5 cm x 2 cm RN-B as of macerations had be previous measurements. Inotes 2/21/16 identified that the anon bilateral buttocks with the assuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks with the easuring 7 x 5 cm and left and on bilateral buttocks wi	F3	309			

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING		05	3/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 309	inflammation, need with nursing staff." care physician) pro identified the the diassociated dermati "meticulous hygiend protection." Review of R5's care identified a risk of smobility and bowel directed to turn, regincontinence every directed staff to app daily, monitor the wand to update the pthere was no evide. Review of the undastaff to turn and posincontinent of stool changed every two progress notes of bidentified the need pericare" and barrie plan, nor the work I During interview on stated she had not on 2/24/16, with MI recommendation to barrier protection for some interventions that new diagnosis from 2/24/16, and th "meticulous" perica	e plan updated on 1/15/16, kin breakdown with impaired incontinence. Staff were 2 hours. The care plan also bly barrier cream to peri area round weekly and as needed, whysician within two weeks if	F 3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	days earlier. During interview on stated that she wor different shifts and reposition him ever buttocks and to che every two hours. Not directed to provide because of R5's sk different skin barrie at the beginning of directed the staff to skin concern." Even though R5 was activities of daily livincontinent of bowe of skin maceration. (MD-B) and the wor (MD-A) identified thand barrier protection to implemented are had increased in six developing in the prin actual harm for F. A procedure, titled: Management, effect Turning and Reposition who are unable to tindependently. This minutes before or 1 predetermined time individualized turnir using: Skin Integrity	dical record on 2/21/16, 11 3/3/16, at 5:10 p.m. NA-J ks with R5 routinely on was aware to turn and y 2 hours so he was off his eck for bowel incontinence A-J indicated she was not pericare more frequently in concerns, or to use a r. NA-J stated, "We get report each shift, and no one has do anything different for [R5's] as dependent on staff for ing, and was frequently el and had two existing areas Both the primary physician und care medical doctor le need for better peri-care on. Theses interventions were not the existing skin maceration ze, with an additional area eri gluteal fold which resulted as. Wound Prevention and etive July 2015, outlines the itioning Program for residents urn and reposition is to occur between 15 5 minutes after the es. "Communicate the ing and repositioning schedule of Assessment; prevention and an, Care Deliver Guide/Nursing	F 30	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ISTRUCTION		E SURVEY IPLETED
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F 309	Continued From pa	ge 12	F3	09			
	diagnosis of heart f edema, and identificare. R23's annual identified R23 had s and the quarterly M R23 required exten daily living, and had present. During an observati R23 was sitting in h	cord dated 9/30/15, included ailure, chronic kidney disease, ed R23 was receiving hospice MDS dated 10/12/15, severe cognitive impairment, DS, dated 1/13/16, identified sive assistance for activities of I no venous or arterial ulcers ion on 3/2/16, at 1:32 p.m. is wheelchair in the hallway					
	lower extremities. Review of R23's Sk Insufficiency Ulcer/deach leg and dated were present on ad "excoriation," and hred, foul odor drains wound was 30 cm (cm in width, and the was 45 cm in length were no additional structure in the form directed staff that assessments, and the width, depth, color of tunneling/undermin were blank. Review of the facility regarding that assessments and the width, depth, color of the facility regarding that assessments.	to include the date, length, of drainage, color, odor, ing with depth, both forms y EHSI Skin Assessment form					
	for R23 dated 11/25	5/15, identified a picture of the of a body with hand drawn					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION ING		X3) DATE SURVEY COMPLETED
		245186	B. WING			03/03/2016
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, CITY, 7505 COUNTRY CLUB I GOLDEN VALLEY, M	DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY)	
F 309	lines and arrows to wounds, weeping le An Admission Skin included hand draw with, "cellulitis" writi were no further skii for R23's bilateral le Review of R23's Conserview Summary, 1/19/16, under Skir skin/wound issues the record review in treatments to his bing Skin Integrity Assest Treatment Care Pla "Lymphedema BLE edema [with] weeping Review of progress 2/21/16, identified Frand treatment applisize, location, color bilateral lower legs notes. The 2/22/16 [resident] legs are of worseLegs have socks were so soal drainage they were were no additional appearance of R23 from 2/23/16 until 32/22/16, notes iden smell" and socks and drainage. R23's physician's o "Bilateral lower ext	both lower legs, with "weeping egs" written beside the picture. Assessment dated 1/7/16, on marks on both lower legs ten beside the picture. There in assessment forms identified ower extremities. Imprehensive Care Plant dated 10/20/15, 1/7/16 and in/Wound, included, "No since last review." However indicated R23 had ongoing lateral "weepy" legs. R23's issment: Prevention and indicated, in [bilateral lower extremity]	F3	009		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	` '	COMPLETED	
		245186	B. WING		C	3/03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		G/CG, <u>=</u> G-7
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	both legs and feet, red stripe) tubular of toes to 1 inch below Administration Rec to complete this tree. During an interview stated she was unsbeen "weeping", she since December 20 assessment and mextremity "weeping the nursing progres Administration Rec location, size, drain description of the a RN-H stated, "They what we are assess expectation." Review of R23's Tand 2/16, lacked do or monitoring of R2 to determine if they During interview or stated R23's legs a cleaned, dried and on the areas. They absorbent dressing fluid), because their	cover with edema wear (large, compression stocking from w knee." R23's Medication ord dated 2/16, directed staff	F 3	09		
	lower extremities a day, and being trea Bacitracin and Atra	ently had "weeping" bilateral re soaked and washed twice a ted with different ointments, actain. The facility has not ared R23's "weeping" legs, and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245186	B. WING _		03	/03/2016	
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	periwound condition symptoms of infect if R23's legs were intreatment was effect. Review of the facilitiextremity Ulcer Inter 7/15, directed staff of wound healing by depth of the wound include drainage/extunneling/undermin wound edges, anat and symptoms of intissue. Also include the wound treatmen weekly assessment. DIALYSIS R86's significant chrough (MDS) dated 2/10/10 cognition and received buring interview on stated she just star been hospitalized report in her chest the managing for her.	cation, size, drainage, n, wound edges, signs and ion, pain or odor to determine healing and if the current ctive for R23. Ty's procedure: Lower ervention and Treatment, dated to document the progression y measuring length, width, and , and documentation should cudate, color, odor, ing, periwound condition, omical location, pain, signs affection, and wound base d, "Regardless of who is doing nt, Nursing Services will do the	F 30	,			
	dialysis when she wased a port on her RN-E stated the faccommunication boo	vas recently hospitalized, and right chest wall for access. cility used a binder (a bk) to help manage R86's care and they send the binder with					

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		245186	B. WING		03/	03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	, 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 16	F 309	9		
	dated 2/23/16, iden	emodialysis Treatment record ntified R86 had received a total atments at the off-site dialysis				
	Record, a tool used care with the off-sit The form used thre dialysis center to de notes for R86's car	Dialysis Center Communication of to ensure collaboration of the dialysis clinic, was reviewed. The spaces for the facility and ocument pertinent results and the including vital signs, cations. R86's records were ified the following:				
	pre/post dialysis do dialysis nurse did n R86's treatment, in work, if any access condition, or how s treatment even tho	ity nurses completed R86's ocumentation, however the lot record any information on cluding any completed lab complications, of changes in the tolerated her dialysis ugh R86 was a new dialysis to record these items were				
	pre-dialysis docum nurse and returning any information on the treatment since spaces to record the	ity nurse completed R86's entation, however the dialysis g facility nurse did not record record of how R86 tolerated as she was new to dialysis. The ne completed vital signs, ations, and any completed lab				
	pre and post dialys dialysis nurse did n R86's treatment, in	cility nurses completed R86's is documentation, however the not record any information on cluding any completed lab a complications, or changes in				

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	condition even thore The spaces to record The spaces to record On 2/29/16, the factoric pre-dialysis document to complete their documentation inclusive present even dialysis patient. The was left blank. There were no treat 2/12/16, 2/15/16, 2/15/16, 2/15/16, 2/although R86's Heidentified she received with [R86]" to her converted to the completed because communication to complete the example to the properties of the properties of the complete the record was, "Just not enough to complete the record was the complete the	augh R86 was new to dialysis. Ord these items were left blank. Callity nurse completed R86's entation, and the dialysis nurse umentation. However, the rse did not complete any uding identifying if any signs or ling, low blood volume, or pain though R86 was a new e spaces to record these items of the services on these dates. Attention of the services on these dates. Attention of the services on these dates. And the services on the binder dialysis treatments, and the services of the services	F 30	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245186		245186	B. WING		03/03/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	When interviewed on 3/3/16, at 1:09 p.m. RN-B stated R86's dialysis communication book (binder) was used for communication between the facility and off-site dialysis clinic and it was, "Supposed to be completed" adding it was, "A communication tool between the center and us [facility]." Although R86 was new to dialysis treatments and had received eight treatments, there was no coordination of care completed with the dialysis center and facility to ensure R86 tolerated her dialysis runs which started February 8, 2016. A facility policy on dialysis care was requested, but none was provided. 483.25(a)(2) TREATMENT/SERVICES TO		F 30	9	ťΩ	4/12/16
				dining services has been reviewed updated 2.All residents requiring assistance dining services have been assesse plan of care reviewed and updated indicated 3.Facility staff will be educated on pregarding residents requiring assist with eating. 4.DON or designee will complete residents.	and with ed and as policy tance	

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	245186		B. WING			03/03/2016		
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER				7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OULD BE COMPLÉTIC		
F 311	from staff for eating R90's nutrition risk identified R90 was staff to, "Assist with identifying R90 recomplete [her] me During observations 8:08 a.m. R90 was other residents and food consisting cound a banana. Read and was trying to pher plate using the the fork using the the table. R90 the chest and closed hypractical nurse (LF gave R90's tablem offering assistance opened her eyes a her plate of food, swatching them eat again came to R90 tablemate who had table at 8:19 a.m. or encouragement R90 picked up a splate and took seven the piece of toast of table. At 8:29 a.m. came to R90's table food and offered the composition of the R90. NA-D left offering any encouragement R90.	required supervision with set-up g. c care plan dated 10/2014, at nutritional risk and directed h meals as needed," further quired, "Extensive Assist to	F3	311	weekly audits on residents requiring assistance with eating for 4 weeks, audit results will be reviewed at QA tracking and trending. QAPI team of adjust audit schedule accordingly to trending identified.	All PI for will then		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 311	R90 opened her et table at her tablem before lowering her closing her eyes as since observation pulled up a chair to offered her assistathis?" NA-E helpe glass of apple juice provided assistant good." NA-E proviuntil 9:10 a.m. who table to help other all of her banana, juices after being from staff. When interviewed member (FM)-F st enough staff to hele at, "I wish there we FM-F had visited F and noticed R90 d sat and cued her to would often play wincorrectly to eat. During interview of stated R90 would a eating, but staff we assist her with all reat at the same tin help."	age 20 onto her chest. At 8:37 a.m. yes and looked around the lates and the food on her plate, in head back onto her chest and gain. At 8:49 a.m. (41 minutes of meal service began) NA-E of the right side of R90 and lance, "Shall we have some of d R90 pick up and hold a full expeeled the banana, and let to eat; R90 stated, "That's ided R90 assistance with eating en NA-E stood up and left the residents. R90 had consumed and nearly all of her toast and provided assistance with eating on 3/1/16, at 1:38 p.m. family ated she did not feel there was in p R90 and the other residents was more help at meal times." R90 before during meal times idnt eat well unless someone of do so, and FM-F stated R90 ith her silverware or use it as 13/2/16, at 9:23 a.m. NA-F at times refuse assistance with the energy and stated R90 had to because their was not enough oom to help all the residents ne, and stated, "We need more on 3/2/16, at 11:29 a.m. RN)-C stated staff should be	F 311				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 311 F 312 SS=D	offering assistance they notice she is n are] supposed to as A facility policy on e requested, but none 483.25(a)(3) ADL C DEPENDENT RES A resident who is undaily living receives	and cues to R90 for eating if ot eating on her own, "[Staff esist her, or try to." eating assistance was e was provided. EARE PROVIDED FOR	F3				4/12/16
	by: Based on observat review, the facility fa ambulation services or maintain the resi of 1 residents (R84 Findings include: R84's quarterly Min 1/7/16, identified R8 impairment, require transfers, physical a was on a restorative R84's Therapy Rec Restorative Program staff were to ambul	ommendations for a m dated 10/23/15, identified ate with the resident three g a wheeled walker from his			1.R84 has been re-assessed for restorative ambulation and plan of c and nursing assistant care guides habeen updated. 2.All residents with recommended restorative ambulation plans have be reviewed to ensure their program is careplanned and communicated on nursing assistant care guide. 3.Nursing staff will be educated on careplanning restorative ambulation programs on the nursing assistant care sheet, and ensuring programs are being followed. 4.DON or designee will complete rail weekly audits to include restorative ambulation programs being careplan and communicated on the nursing assistant care sheet and programs is	een the ve	

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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIT DEFICIENCY)		BE	(X5) COMPLETION DATE
F 312	R84's care plan dat to provide assistant room, and R84 requive wheelchair for mobi identify staff were to meals. No restorative flow ambulation for R84 When interviewed of medication aid (TM self-propel the wheelchair to the wheelchair was unsafe independently, and restorative nursing for R84 to participate PT-A stated once the forwarded to nursing unless nursing notification, or if there further services. Preceived any referrance and preservices and the property of the preceived and the pre	ced 10/15, identified staff were be to and from the dining uired a cane, walker, or ility. However, it did not assist with ambulation to sheets were available for assist with ambulation to sheets were available for an 3/2/16, at 11:43 a.m. trained A)-A stated R84 does not elchair, and staff push him in the dining room. On 3/3/16, at 2:42 p.m. On 3/3/16, at 2:42 p.m.	F3	312	completed x 4 weeks. All audit rest be reviewed at QAPI for tracking a trending. QAPI team will then adjuschedule accordingly to trending identified.	nd	
	was documented or	n was ordered and provided, it n the computer program. o find any order for R84 to					

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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 312	ambulate. When interviewed of	ge 23 on 3/3/16, at 4:27 p.m. ed nurse (RNC)-A stated	F 31:	2		
	recommendations f the care plan, into conursing assistant ca staff were provided ambulation progran	rom therapy are transferred to care tracker, and onto the are sheets. RNC-A stated education on providing the n, and the registered nurse hly the effectiveness of the				
	PT-A assisted R84 wheeled walker and wheeled walker was time, as no walker was pt-A stated R84 ar and no change was since he was discharged she was not	ion on 3/3/16, at 4:55 p.m. to ambulate, with the use of a d transfer belt. PT-A stated a s provided from therapy at this was available in R84's room. Inbulated with a shuffled gate, a noted to R84's ambulation arged from therapy. PT-A aware R84 was not provided ince as recommended.				
F 314 SS=G	Facility policy on re- requested, but not p 483.25(c) TREATM PREVENT/HEAL P	ENT/SVCS TO	F 31	4		4/12/16
	resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received.	rehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that lible; and a resident having eives necessary treatment and e healing, prevent infection and from developing.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING _			03/0	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7505	EET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	by: Based on observareview, the facility for residents (R89, R1) services to promote development of preactual harm for R89 ulcer became wors implemented. This R89. Findings include: R89 was re-admitted for fever, shortnessed discharged back to Hospital Discharged discharge summary II (partial thicknesses shallow open ulcer without slough. May open/ruptured seru filled blister. Preserulcer without slough on the coccyx and the LE [lower extreed The Admission Skin indicated R89 had a crythema of intact as skin ulceration. In indiscoloration of the induration, or hardreed residuals and services and the induration of the induration, or hardreed residuals and services and ser	NT is not met as evidenced tion, interview, and document ailed to ensure 3 of 4 15, R60) received care and e healing and prevent the essure ulcers. This resulted in 9 whose stage II pressure e when interventions were not resulted in actual harm for ed to the hospital on 1/21/16, sof breathe, and was the facility on 1/25/16, per the Summary dated 1/25/16. The y also noted R89 had a stage loss of dermis presenting as a with a red pink wound bed, y also present as an intact or m-filled or serosanguinous as a shiny or dry shallow or bruising) pressure ulcer "had another open wound on	F 3	1 pua 2 au 3 in pir dir u fc puu t 4 w pa reatra	1.R89 and R60 skin assessments plan of care have been reviewed an appdated as appropriate. R115 is not resident at the facility. 2. All residents with pressure ulcers assessed and plan of care reviewed appdated as indicated. 3. Nurses will be re-educated on applementing and following wound protocol for residents with pressure accluding proper assessment and accumentation, implementing anterventions, and monitoring of presiders. Nursing staff will be educated on a present and accumentation and residents with pressure prevention and residents with pressure acceptance of the pressure relieving devices or eachniques. 3. DON or designee will complete reversity audits to ensure staff followed and of care for residents at risk for altercation, including toileting and appositioning, for 4 weeks. Results audits will be reviewed at QAPI for racking and trending. QAPI team will adjust audit schedule accordingly to rending identified.	and of will then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF	TATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R89's progress no signs and symptor and there was no note commented to cream to the reside medical lacked and the heel. R89's quarterly Mi 12/4/15, indicated cognitive impairment assistance with all except for eating, development, but R89's quarterly MI resident remained had no current prefer MDS did not ident re-admission on 1. R89's Skin Integrit Treatment Plan of revised and indicate pressure ulcer on to float (relieve prefer bootie" onto the rinot indicate how or repositioned. The wound was to be ridirected to docum.	te dated 1/26/16, indicated noms of the coccyx being open mention of the LE wound. The he staff would use the barrier ent's "bottom." However, the y evidence of skin monitoring of nimum Data Set (MDS) dated the resident had severe ent, required extensive activities of daily living (ADL) was at risk for pressure ulcer had no current pressure ulcers. DS dated 2/10/16, indicated the at risk for pressure ulcers, but essure ulcers. The quarterly ify the stage I ulcer noted upon	F3	314	DENOLITY		
	indicated, "New bl	tes dated 2/25/16, at 6:00 p.m. ister found to R [right] heel. x 5 cm [centimeter]." The note					

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F 314	the bootie. The Proof daily wound more of daily wound more R89's progress not indicated the prima R89's pressure ulcowere given to elevate continue to monitor. R89's progress not dressing change wheel pressure ulceramount of bleeding when heel touched. The undated and undid not specify R89 nor were staff direction boot on the riskin noted staff we skin checks. Assist PRN [as needed]." R89 was continuous 6:20 a.m. to 7:29 a on his back, and bothe mattress. The roon that was to float nursing assistant (I stated R89 did not NA-A stated she did supposed to be float on 3/2/16, at 11:30 was interviewed and to see the wound Na-A stated she wound Na-B stated R89 did not Na-A stated she did supposed to be float on 3/2/16, at 11:30 was interviewed and to see the wound Na-A stated she wound Na-B stated R89 did not Na-A stated she did supposed to be float on 3/2/16, at 11:30 was interviewed and to see the wound Na-A stated she wound Na-B stated R89 did not Na-A stated she did supposed to be float on 3/2/16, at 11:30 was interviewed and to see the wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated she wound Na-B stated R89 did not Na-A stated	aff would float heels and add gress Notes lacked evidence litoring. e dated 2/25/16, at 8:30 p.m. ry physician was notified of er on the right heel, and orders ate legs, apply a soft boot, and edited 3/1/16, indicated a las done to the resident's right and there was a scant, and, "only complains of pain." Intitled NA assignment sheet was to have the heels floated, and that R89 was to wear a ght foot. The section under re to complete, "Q [every] shift resident with back scratcher. Isly observed on 3/2/16, from lim. in bed. R89 was sleeping of theels were lying directly on ight heel had a blue foam boot R89's heel. At 7:29 a.m. NA)-A was interviewed and have the heels floated, and do not believe staff were lating the resident's heels. a.m. registered nurse (RN)-B d was asked if R89 was going ID today. The wound list was at R89's name was not on the	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03	/03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, Z 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	observed to assess MD-A assessed the heel and stated, "T time ulcer. That is injury [an injury to a below the skin's suprolonged pressure Anticipate that will piece of dead tissus surface of the skin MD-A also stated the relief to the heels wheels. During interview or registered nurse (Fobserved not to have remarked R89 had right foot and it was treatment to the riginated. RNC-A verification of the blue the heels. RNC-A in was the plan of care. The health unit coopserved on 3/2/16 computerized NAs the information of the heels was not on the During observations 8:27 a.m. R84 was dining room, with the tothe side, and R8 placed directly on the side of the side	p.m. physician (MD)-A was a R89 during wound rounds. That's going to mature to a big 4 cm by 6 cm deep tissue a patients underlying the elements of the patients of the properties and the patients of the properties of the properties and the patients of the properties and the properties are properties and the properties and the properties are properties are properties are properties and the properties are properties are properties and the	F3	314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING			03/	03/2016
-	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	moved the right for placed R89's right to R89 to his room. To device placed on the During interview on stated both of the few wheelchair were minowever, staff proves the facility on 3/2/10 R89's feet would be the wheelchair if no During interview on stated R89's feet were right on the stated R89's feet were right on the wheelchair if no stated R89's feet were right on the wheelchair if no stated R89's feet were right on the weight of the weight o	ght foot. At 8:57 a.m. NA-B at pedal in front of R89, and foot on the pedal, and brought nere was no pressure relieving	F3	114			
	stated the first time ulcer was 3/2/16, d MD-A. RN-B stated 1/25/16, from the h but was not sure if round list at that tim were to be floated, when he was in the was aware R89 did wheelchair from 2/2 Grid - Pressure/Ver form dated 2/25/16 Skin Grid Sheets hill to a stage III pressure loss involving dama subcutaneous tissubut not through, un	3/3/16, at 11:13 a.m. RN-B she had seen the pressure uring wound rounds with R89 returned to the facility on ospital with a pressure ulcer, R89 was added to the wound ne. RN-B stated R89's heels and foot rests were to be used wheelchair. RN-B stated she not have foot pedals on his 25/16 to 3/2/16. R89's Skin nous Insufficiency Ulcer/Other, was reviewed with RN-B. The ad been changed from a stage sure ulcer (Full thickness skin age to or necrosis of the that may extend down to, derlying fascia. The ulcer as a deep crater with or without					

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	, 33		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE	
F 314	she did alter the do stated the pressure ulcer during his rou indicated R89 had. During interview on stated education won staging a pressure assessment form, a stage II pressure ulstatement contrained 3/3/16, at 11:13 a.m. aware the document to a stage III, and sthat; This is very set on the right foot. At nurse (LPN)-D obs R89's heel was directly floating to relieve plassessed R89's heep ressure ulcer on the foam inside the the sheep wool linit pressure to the pressure to the pressure uncarrectly assessments and in Skin Integrity Assest Treatment Care Plasses Treatm	accent tissue). RN-B indicated ocumentation because MD-A e ulcer was a stage III pressure ands on 3/2/16, however, MD-A a deep tissue injury. 1 3/3/16, at 1:02 p.m. RNC-A ould be provided to the nurses are ulcer. RNC-A stated she and rounds on 2/25/16, with a her how to fill out the and the pressure ulcer was a loer at that time (that dicated what RN-B stated on n.). RNC-A stated she was not not not a stated, "She [RN-B] can't do	F 314				

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F 314	repositioning and on ot receive the care healing of the right went from a stage that caused R89 has that caused R89 has R115's admission R115 had moderate needed extensive a was totally dependent risk for pressure utidentified R115 had for the bed and chaturning/repositioning interventions to propose and hydration manate of manage skin proposed resident had diagnown ascular disease at R115's Skin Integrit Treatment Care Planad a pressure ulcer to the provide treatment provide treatment provide treatment provide treatment for the pressure wound medial buttock folloof the pressure ulcer of the pressure ulcer to the provide treatment pro	wheelchair, use turning and off load heel pressure. R89 did to and services to promote the heel blister. The heel blister II to a deep tissue injury and tarm. MDS dated 1/20/16, indicated the cognitive impairment, the assistance with bed mobility, thent on staff for transfers, was a fulcers, and had an unhealed licer on admission. The MDS that a pressure reduction device the air, was on a fulger and the area of the area o	F 314				
	R115's had two ulc	ure ulcers were observed. ers one to the coccyx and one line sacrum. Both wound beds					

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F 314	were beefy red, with edges intact and single NP-A stated the prothey were healing. R115's February 20 staff to do a daily the including cleanse the skin prep, and cover in February the tredays were marked. When interviewed stated R115 was to the sacrum presonant Allyven, and the weevery Wednesday, ulcer treatment is refused treat the treatment sheet and if the treatme	chout drainage, odor, with howed no signs of infection. essure ulcers appeared as 016, treatment record directed reatment to the pressure ulcers he wound, apply Santyl, apply er with adhesive foam. 7 days atment was left blank, and 4 as refused. on 3/3/16, at 3:43 p.m. RN-G o have a daily dressing change sure ulcers using Santyl and bund physician sees R115 RN-G stated R115's pressure not always completed because ments at times. RN-G stated its indicated resident refusals, at sheets were blank and not l, it indicated the pressure ulcer	F3	314		
	R60 was cognitively assistance with be risk for developing current pressure undertended reduction device for identified R60 had and wound infection R60's Skin Integrity	Assessment: Prevention and				
	resident had a pres	an dated 1/16, indicated the ssure ulcer to the right ischium, o provide treatment per MD				

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	REET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE 6 LDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	staff to apply Santy with foam dressing pressure ulcer to the On 3/3/16, at 9:27 observation of pressure to the January 2016, to cleanse the pressure to the January 2016, to cleanse the pressure it with non addys the treatment completed with no treatment was not days was marked at The February 2016 staff to cleanse the and cover it with no 28 days the treatment out of 28 days the reatment out of 28 days ther circled (which indiccompleted), and or documented as referenced to allow the treatment of a daily not aware why staff ulcer dressing every day, howeved the description of the presence of the pre	orders dated 1/27/16, directed of, apply skin prep, and cover once daily to the Stage III he right ischium. a.m. R60 refused surveyor sture ulcer. treatment record directed staff sture ulcer, apply Santyl, and othesive foam. Three out of five was not documented as indication as to why the completed, and one out of five as refused. 5, treatment record directed pressure ulcer, apply Santyl, on adhesive foam. Nine out of ent was not documented as so blank with no indication as to was not completed, and seven e were staff initials which were eate treatment was not ne out of 28 days were fused. on 3/3/16, at 3:12 p.m. R60 but cream on her "bottom" r, staff did not change the basis. R60 stated she was f did not change the pressure ry day, and stated she had not own nursing to complete the	F3	14			

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	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
state to be is no lack complete repo it. Whe state complete had l press complete nurs to er Whe state acco The and most deve in so effor risk f and press complete nurs to er Whe state acco The and most deve in so effor risk f and and and and man and	e completed dat able to comport staffing. Rivelete the pressorted off to the information interviewed of pressure ulcoleted as ordered due to large and interviewed of sure ulcer treatment due to large are directed due to large are directed facility policy/p. Treatment date a vigilant nursing lopment and of me residents. Its will be directed actions, providing treatment dated 7/lents upon admit dentify individuaging pressure friction and she facility nursing lopment and of the large actors.	essure ulcer treatment ordered ally to her coccyx, however, staff lete this everyday because of V-I stated if she is not able to sure ulcer treatment, it is next shift so they can complete on 3/3/16, at 3:50 p.m. RN-H are treatments should be red by the physician, and she are treatments that the timent(s) could not be ack of staffing. RN-H stated at to pass it on to the next shift ment is done as ordered. On 3/3/16, at 5:43 p.m. RNC-A all treatments to be done cian orders. In coccdure Wound Prevention and 7/15, "recognizes even the fing care may not prevent the or worsening of pressure ulcers and the following: managing ng preventative interventions	F3	14		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315 F 315 SS=D	483.25(d) NO CATIRESTORE BLADD Based on the resident assessment, the faresident who entersindwelling catheter resident's clinical content catheterization was who is incontinent of treatment and servinfections and to refunction as possible. This REQUIREMED by: Based on observareview, the facility for catheter was insert according to the phoresidents, (R5), revicatheter. Findings include: R5's quarterly Minital/6/16, indicated he impairment, require for activities of daily bathing, eating, and indwelling Foley can euromuscular dys.	HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder ed. NT is not met as evidenced tion, interview, and document ailed to ensure a suprapubic ed using sterile technique and ysician orders for 1 of 1 iewed with a suprapubic ed complete staff assistance of living (dressing, grooming, dressing, grooming	F 3		1.R5 suprapubic catheter plan of cawas reviewed and updated as appropriate. 2.All residents with urinary catheters been reviewed and plan of care updas appropriate. 3.Nursing staff will be educated on procedure for working with suprapul catheters. 4.DON or Designee will complete raudits regarding catheter reinsertion techniques monthly for 3 months. A results will be reviewed at QAPI for tracking and trending. QAPI team withen adjust audit schedule according the trending identified.	s have dated proper bic andom n udit	4/12/16
	(suprapubic) cathet	ent was to have his S/P er changed every month, and or plugged, and was to use a					

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F 315	22 or 24 FR (french liquid unit of measure included neurogeni (urinary tract infection R5's care plan, more indicated the resider related to neuroger and recurrent UTI's resident was to have catheter, and staff sterile technique for reinsertion." During observation 10:22 a.m. R5's supplace, and Register would need to be reprepare to insert the observed RN-B had of a S/P catheter. I wrong equipment, a RN-B proceeded to placed on non-steril gloves, the end of the S/P catheter with insertion, the sregarding sterile technad been using. Find the sylvanian sterile for the sylvanian sterile for the sylvanian sterile technad been using. Find the sylvanian sterile technad been using to us 22 or 24 FR as directly licensed practical in supplies, including	n)/5 cc's(cubic centimeters) (a prement). R5's diagnosis of bladder and recurrent UTI's ons). Set recently reviewed 1/15/16, and had a suprapubic catheter nic bladder with urine retention of the care plan identified the real 22 or 24 FR suprapubic were directed to, "Follow of the care plan identified the real 22 or 24 FR suprapubic were directed to, "Follow of the care plan identified the real 25 or 26 FR suprapubic were directed to, "Follow of the care for R5 on 3/3/16, at propubic catheter was not in red nurse (RN)-B indicated it eplaced. RN-B proceeded to the S/P catheter, and it was diagastrostomy tube instead RN-B indicated she had the real obtained a S/P catheter. The gloves, requested nursing assistance and had her apply and applied sterile lubricant to catheter and was prepared to eatheter and was prepared to eatheter and was prepared to eatheter and the supplies she included the S/P catheter see was a 26 FR, and not the cated by the physician. NA-A eack additional assistance and at supplies. At 10:31 a.m., urse (LPN)-D arrived with a 22 FR S/P catheter was inserted the S/P catheter was inserted.	F3	315			

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F 315	Continued From pa	ge 36	F 31	5		
F 329 SS=D	requested but not p	EGIMEN IS FREE FROM	F 32	9		4/12/16
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs therapy is necessal as diagnosed and crecord; and resident drugs receive gradubehavioral interventions.	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these				
	by: Based on interview facility failed to ens pressures were mo	NT is not met as evidenced and document review, the ure orthostatic blood nitored for administered nedication for 1 of 5 residents		1.R84 treatment record has been reviewed and updated to reflect neorthostatic blood pressure monitori MD has been updated on results of	ng. The	

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F 329	pain medication was parameters for 1 of for unneccessary in Findings include: R84's quarterly MD diagnoses including (high blood pressuridentified R84 had required extensive was not steady with R84's signed physicidentified orders for (medication to treat milligrams (mg) twiccarvedilol (medicat pressure) 25 mg poinitiated on 5/2/15. to check orthostatic and vital signs to be Review of R84's me (MAR) for March 20 monitor for side efficiency of R84's treat (TAR) identified an orthostatic blood pridentified the follow orthostatic	ness of as needed narcotic s evaluated using adeqaute 5 residents (R66) reviewed nedication use. S dated 1/7/16, identified g heart failure, hypertension e), and dementia. The MDS severe cognitive impairment, assistance with transfers, and nout human assistance. Cian orders dated 2/3/16, amlodipine besylate high blood pressure) 5 ce daily by mouth (po), and no to treat high blood or twice daily which had been The physician orders directed blood pressure once a week exchecked weekly. Redication administration record 016, identified staff were to exts of medications which fatigue, hypertension, and sion. Reatment administration record order dated 5/2/15, to monitor essures weekly on Friday, ing for completion of the essure:	F 329	and reviewed resident plan of care accordingly. R66 physician orders pain medication has been clarified physician and updated to reflect claccordingly. 2. All residents on hypertensive medications were reviewed and Mupdated as necessary for approprimonitoring. All residents on narcomedication were reviewed and ordered clarified for clear parameters as necessary. 3. Nurses will be educated regarding documentation requirements for documentation requirements for documentations, potential side effects unnecessary medications. 4. Pharmacist or Designee will commonthly random audits to ensure adequate drug monitoring and documentation is being completed or designee will complete random audits for 4 weeks to ensure documentation of side effect monimand PRN Analgesic Record/ Pain Sheet is being completed Audit rewill be reviewed at QAPI for tracking trending. QAPI team will then adjuschedule accordingly to the trending identified.	ARS ate tic pain lers ag of the by the hanges ARS ate tic pain lers ag rug ss of the pain lers and the p	
	- January 2016 - December 2015	0 of 5 opportunities 1 of 4 opportunities				

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F 329	- October 2015 1 c - September 2015 Review of R84's Vi Flowsheet from 12/ documentation R84 checked on 12/12/ 2/14/16 and 2/28/16 blood pressure che orthostatic blood pressure che corporate registere orthostatic blood pressure orthostatic blood pressure orthostati	1 of 4 opportunities of 5 opportunities 0 of 4 opportunities tal Sign-Individual Resident (12/15 to 2/28/16 revealed It's blood pressure had been 15, 12/27/15, 1/9/16, 2/7/16, 6. The form listed the single ocks, however, did not included ressure monitoring for R84. on 3/2/16, at 12:45 p.m. d nurse (RNC)-A stated ressures had not been as ordered, and it was her e orthostatic blood pressures	F 329			
	LACK OF MONITO	PRING FOR NARCOTICS:				
	2/18/16, identified I	num Data Set (MDS) dated R66 had intact cognition, of pain, and received needed (PRN) pain				
	identified orders for > "Fentanyl C2 [cor	cian orders dated 2/3/16, r the following narcotics: ntrolled drug] 25 mcg/hr our] Apply 1 patch and ours," and				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 329	change every 72 hd > "Methadone HCL tabs [tablets] [30 m and > "Oxycodone [a na Tablet 1-2 tabs[ta every bedtime as n Review of R66's Markecord (MAR) for 1 following: -MAR dated 1/2016 doses of the as-need during the month. In documentation to dordered 5 mg dose needed narcotic marked properties of additional to the second s	mcg/hr Apply 1 patch and burs," and C2 10 mg [milligrams] 3 g] by mouth every bedtime," arcotic pain medication] 5 mg ablets] [5-10mg] by mouth eeded." edication Administration /16 and 2/16 identified the identified R66 received 20 eded narcotic pain medication However, there was no etermine if R66 received the or 10 mg dose of the as	F 3	29			

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F 329	medication. PRN (/ Pain Flow Sheet of identified spacing the administration, pair rating, the medicate the provided medicial fields were left blar. R66's progress not 2/28/16, were revisited to medication had be been provided the medication had be been provided the medication, or any medication had be. When interviewed registered nurse (Fromplaints of pain [medications] to he scheduled narcotic medication two tablets of as-new many tablets of the medication to proving staff should provided and it's effectiveness and stated effectiveness compared to the medication was adward of a would be document interventions, montal services and stated effectiveness compared to the stated effectiveness compared to the stated effectiveness compared to the stated to the state	das-needed) Analgesic Record dated 2/1/16 to 2/29/16, or record the date and time of an description and numerical ion provided, and follow-up to eation. However, all of these as the on the record. Tes dated 1/1/2016 through ewed but lacked documentation se of the as needed en administered, why R66 had as needed narcotic follow up on if the provided	F 32	9			

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 329	use it each time." I unable to determine needed narcotic metime R66 received During interview on assistant director of were expected to use to document a reside effectiveness monisupposed to use the stated she did not the writing range order anymore, "I though ago," and staff shough R66 had medication, the faction of the admit was effective and it was effective a	age 41 staff, "Need to be re-taught to Further, RN-E stated she was e how many tablets of the as edication had been given each the as needed narcotic. a 3/3/16, at 12:56 p.m. the finursing (ADON) stated staff isse the PRN analgesic records dent's pain, and the toring for it, "[They're] at sheet." Further, RN-B think physicians should be side. one to two tabs that was banned a long time uld have clarified the order. orders for as needed narcotic dility failed to ensure staff instered dose, and then inistered medication to ensure an administered scheduled esic. Include data regarding sity, intervention and ervention to manage pain on a Administration policy dated aff to, "Indicate reason for effectiveness of PRN ursing progress notes or on	F 3.	29		
F 332 SS=D	the back of the [MA 483.25(m)(1) FREE RATES OF 5% OR	OF MEDICATION ERROR	F 3	32		4/12/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245186	B. WING		03/0	3/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7:	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	This REQUIREMENT by: Based on observative review, the facility for were administered accordance with physical strength.	ge 42 Issure that it is free of tes of five percent or greater. NT is not met as evidenced tion, interview and document ailed to ensure all medications in a timely fashion in sysician orders and facility esidents (R101) observed to	F 332	1.R101 is no longer a resident at the facility. The facility will provide medications in a safe, professional manner to include right drug, right right dose and preparation, right pa	eason,	
	receive medication resulted in a medic (percent). Findings include: During an observat administration on 3 practical nurse (LP administer R101's radministered Baclo Sulfate ER 15 mg t tablet with various of that time. LPN-H st R101's Morphine S a.m., and Baclofen scheduled for 8:00 an appointment too between 8:30 and 9 been busy this mor R101's admission r diagnoses of parap disorder, and chror Minimum Data Set	during the survey. This ation error rate of 8.3% ion of medication /2/16, at 9:28 a.m., licensed N)-D was observed to medications. LPN-E fen 20 mg tablet, Morphine ablet and Lorazepam 2 mg other medications to R101 at ated she was aware that ulfate was scheduled for 7:00 and Lorazepam were a.m She indicated R101 had ay and wanted to be up 9:00 a.m., but stated, "It's just		right time, right route and right documentation with oversight to en medication delivery system that me professional standards. Medication Administration Records have been audited to ensure residents are recomedications in a safe professional manner. 2. All nurses will receive education regarding the policy of medication administration and seeking out ass if having difficulty completing medical administration timely. 3. DON or Designee will complete reweekly medication administration afor 4 weeks to ensure timeliness of medication administration. All audit be reviewed at QAPI meeting for trand trending. QAPI team will then a audit schedule accordingly to the tridentified.	sure a sets of the sets of the set set set set set set set set set se	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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F 332	almost constantly, pain at night, and I due to pain. During an interview R101 stated he ha abdomen, back, he spasms in his legs medications, espe often given late or them. R101 indica Sulfate and Baclof help with his pain a for the day, and stahis pain on the day late. R101's physician or "Morphine Sulfate ER [extended releatablet1 tab by more "Baclofen [medicas spasms, pain and mouth four times or "Lorazepam [medimg tablet, 1 tab by anxiety. R101's medication dated 3/16, indicated administered at 7:0 p.m., Baclofen was	had difficulty sleeping due to had limited day to day activities of an 2/29/16, at 6:20 p.m., d constant pain in his chest, and and lower arm, and and bladder, and indicated his cially pain medications, were not at all, when he requested ted he needed Morphine en right away in the morning to and stiffness before getting up ated it was difficult to manage as that his medications were orders, dated 2/3/16, included, [medication used to treat pain] ase] 15 mg [milligrams] buth every 8 hours," for pain, tion used to treat muscle stiffness] 20 mg tablet, 1 tab by daily," for muscle spasms, and, cation used to treat anxiety] 2 mouth three times daily," for administration record (MAR), ed Morphine Sulfate was to be 300 a.m., 3:00 p.m., and 11:00 at to be administered at 8:00 a.m., and 2:00 a.m., and	F 33	2		
	Lorazepam was to 12:00 p.m., and 8: During an interview stated, when giving	be administered at 8:00 a.m.,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 332	medications were g	ge 44 give them," and indicated if iven outside of that time a considered a medication	F3	332			
F 353 SS=E	Administration, date licensed nurse and/ check the following Right medication, F Right route, Right re 483.30(a) SUFFICE	by's procedure, Medication and 7/15, included, "The for medication assistant will to administer medication: Right dose, Right dosage form, esident, and Right time." ENT 24-HR NURSING STAFF	F3	353			4/12/16
	provide nursing and maintain the highes and psychosocial w	eve sufficient nursing staff to d related services to attain or st practicable physical, mental, rell-being of each resident, as dent assessments and care.					
	numbers of each of personnel on a 24-h	ovide services by sufficient in the following types of nour basis to provide nursing in accordance with resident					
		d under paragraph (c) of this urses and other nursing					
	section, the facility	d under paragraph (c) of this must designate a licensed charge nurse on each tour of					
	This REQUIREMEN	NT is not met as evidenced					

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F 353	review, the facility finursing staff to menter of 3 residents (Redaily living, and for complained about of 9 residents (R39, FR88, R137, R77), 2 FM-F), and 7 of 7 RD-A, NA-F, LPN-A concerns with the lefacility. Findings include: ASSESSED RESIDMET: See F311 as the fact assistance with eat residents (R90) revolving (ADLs). See F364 as the fact assistance with eat residents (R90) revolving (ADLs). See F364 as the fact assistance with eat residents (R90) revolving (ADLs). See F364 as the fact assistance with eat residents (R90) revolving (ADLs). See F364 as the fact assistance with eat residents (R90) revolving (ADLs). During interview or stated he did not feet and residents (ADLs). During interview or stated he did not feet and residents (R90) revolving interview or stated he did not feet and residents (R90) revolving interview or stated he did not feet and residents (R90) revolving interview or stated he did not feet and residents (R90) revolving interview or stated he did not feet and residents (R90) revolving (R90	tion, interview and document failed to provide sufficient et assessed resident needs for 90) reviewed for activities of 1 of 2 residents (R66) who cold food. In addition, for 9 of R158, R68, R66, R110, R127, 2 of 3 family members (FM-E, staff members (NA-H, CDM-A, A, SM-A, SM-B) who identified ack of adequate staff in the DENT NEEDS NOT BEING cility failed to ensure timely sing was provided for 1 of 3 riewed for activities of daily activities for 1 of 2 residents ned about cold food. ERNS WITH LACK OF FING: Simum Data Set (MDS) dated 1 R39 had intact cognition and assistance with his activities of	F 353	1.Facility has reviewed staffing levensure facility has sufficient staffin to meet resident needs. This is do through daily evaluation of residen census and acuity levels by the DC designee. Also Refer to F282, F31 F312, F314, F332, F364 plan of correction. 2.Residents in the facility will recei by skilled/experienced staff that ar supervised to ensure care needs a being met. Administrator/DON or designee will review scheduled stadily to ensure adequate staffing leand to ensure appropriate quantity quality, and composition of staff. 3.Staff will receive education regar sufficient staffing levels and provid nursing and nursing related service accordingly. 4.Executive Director will complete weekly audits x 4 weeks to ensure adequate staffing levels are providinclude interviews with staff. Caring Partners will complete weekly audit regarding customer service and resatisfaction with cares. Audits will reviewed at QAPI meeting and QA will adjust audit schedule appropriabased on findings.	g levels ne t DN or 1, ve care e are diffing evels random ed to g its sident be PI team	

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F 353	they need more stated to go to bed and stated things to do before be awhile" before he come, [it] just takes. R158's admission of R158 had intact cognition assistance with his During interview on stated he did not fer R158 stated the stated he did not fer R158 stated the stated intact cognition assistance with her During interview on stated she did not for staff to ensure she manner. R68 required a result. R68 report do not have time to sometimes it takes call light answered. R66's annual MDS had intact cognition assistance to comp During interview on stated there was not residents at the facts	aff." R39 stated he will request aff will tell him they have other they can help him, and it, "Will e received help, "They will awhile." MDS dated 12/24/15, identified gnition and required extensive activities of daily living (ADLs). 2/29/16, at 6:49 p.m. R158 el the facility had enough staff. aff had too much to do, and not aplete it and spend adequate ents. S dated 2/9/16, identified R68 and required extensive (ADLs). 2/29/16, at 6:52 p.m. R68 eel the facility had adequate received care in a timely ired two staff to assist her with during the night, there is only working so she had to wait and ontinence product changed as ted staff always tell her they help her when asked, and up to 45 minutes to get her	F 35	53			

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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	•	
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F 353	answered timely, so to two hours" for so her, "The care is so R110's quarterly MI R110 had intact cogassistance to comp During interview on stated he did not the facility to help reneed. Staff often to return to help him. I having to sit in stoo having a bowel movuncomfortable. R127's quarterly MI R127 had intact cog During interview on stated there was not R127 stated he offer to receive his medicupsets him. R88's annual MDS had intact cognition assistance to comp During interview on stated she did not for the facility because with toileting or incomposition as she needed. R8 scheduled bathing of consistent basis whactivities.	ated call lights were not ometimes having to wait, "Up meone to answer it and assist to bad." OS dated 1/7/16, identified quition and required extensive lete his ADLs. 3/1/16, at 8:50 a.m. R110 ink there was enough staff at esidents get the care they ell him to wait and then do not R110 reported often times I waiting to get help after vement which made him feel on the staff at the facility. It is to enough staff at the facility. It is to wait for long periods eations and meals, and it dated 1/15/16, identified R88 and required extensive lete her ADLs. 3/1/16, at 10:19 a.m. R88 eel there was enough staff at she was not being assisted ontinence care every two hours as stated she didn't receive her or morning cares on a nich often made her late to	F3	353			
	R137's quarterly MI R137 had intact cog	OS dated 11/26/15, identified gnition.					

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F 353	During interview on stated she did not if the facility to help he the care they need hours were the wor significant pain and so she called anoth in the building to he "It's like no one up stated it had taken, longer" to get her chelp. R77's quarterly MD R77 had intact cog assistance to comp During interview on stated he did not fee help deliver meals in the facility becaupain medications lated the compain medications lated the care the received the care the further, FM-E statemost of his wife's comough staff to help During interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on stated there was not FM-F had noticed on the following interview on	in 3/1/16, at 11:20 a.m. R137 feel there was enough staff in her and the other residents get. R137 stated the overnight rest, and one night she had at there was no staff to help her her resident on a different floor ave them send help up to her, here at all." Further, R137 and minutes, sometimes hall light answered and receive all light answered and receive all light answered and receive his ADLs. and 3/1/16, at 11:31 a.m. R77 feel there was enough staff to for medications to the residents are he receives his food and the often times. NS WITH LACK OF FING: on 3/1/16, at 11:21 a.m. family ated he did not feel there was facility to make sure residents hey needed adding his wife medications late as a result. The definition of the ends up doing hare because there is not	F3	53			

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F 353	Continued From p	age 49	F 353	3		
		NS WITH BEING UNABLE TO E DUE TO LACK OF				
	assistant (NA)-H s don't have "quite e assigned cares co meal times. NA-H hardest, and the s	n 3/2/16, at 6:08 a.m. nursing tated staff often felt like they enough time" to get all of the mpleted, especially before stated the weekend staffing is taff are often short NAs which ressful" for the residents and				
	manager (CDM)-A were interviewed. nursing staff to he was an "ongoing p dietary departmen food. RD-A stated assist with meal times.	a.m. the certified dietary and registered dietician (RD)-A CDM-A stated the lack of p pass meals and room trays roblem" which affected the ts ability to serve palatable the lack of nursing staff to mes was, "affecting my e residents point blank."				
	stated some reside assistance to eat to staff to help everyoneed more help." reported the conce	on 3/2/16, at 9:23 a.m. NA-F ents often have to wait for because there is not enough one eat at the same time, "we NA-F stated he/she had erns to the assistant director of r nurse in the past.				
	practical nurse (LF needed to be more for the residents. required, "total car staffing did not allo	n 3/2/16, at 1:31 p.m. licensed PN)-A stated she felt there e staff on the floor to help care Several of the residents e" and the lack of adequate ow the floor staff enough time to uld] be nice to have one more				

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F 353	on the floor." On 3/2/16, during a stated the facility in care was being cororders from the phitimely, and treatmed completed at all be the staff to do them neglected, and the getting worse lately (DON) changing so held accountable for their assigned task lack of staff was so the facility should complete their assigned task lack of staff was so the facility should complete their assigned task lack of staff was so the facility should complete their assigned task lack of staff was so the facility should complete the lack of staff coroperated the nurses and the lack of staff coroperated the nurses and the residents more the facility needed the residents more on 3/3/16, at 2:02 consultant (RNC)-director (AED) were used a "minimum so changed it based complete the staff of the st	an anonymous interview, SM-B eeded more staff to ensure impleted. SM-B stated at times sysician don't get transcribed ents are being missed or not ecause there was no time for in. SM-B stated residents were staffing at the facility was with the director of nursing everal times and no staff being or errors and not completing its. Further, SM-B stated the orderimental to the residents, close down. In anonymous interview, staff atted the staffing at the facility y's" and, "we [staff] need more in a wait for cares, and added intributes to increased in the residents get upset. SM-A and social workers only help here" and when the staff administration it was blaining. Further, SM-A stated more staff so they, "could give	F 35			

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F 364 SS=D	staff from an outsid The RNC-A stated to of staff concerns abresident cares. Although resident, find call lights do not genot served timely at assistance with actification facility had not identification concerns despite most staff complaints. A facility policy and requested, but none 483.35(d)(1)-(2) NL PALATABLE/PREFIEach resident receif food prepared by most value, flavor, and appalatable, attractive temperature. This REQUIREMENT by: Based on observative review, the facility for served hot and palatable.	e agency several months ago. The facility had not been aware pout inability to complete amilies and staff had stated to answered timely, meals were not they had to wait for vities of daily living. The tified there was a staffing fultiple resident, family and procedure on staff was a was provided. ITRITIVE VALUE/APPEAR, ER TEMP ITRITIVE VALUE/APPEAR, ER TEMP ITRITIVE VALUE/APPEAR, ER TEMP ITRITIVE VALUE/APPEAR, ER TEMP	F 353	Reference is receiving palatable meals proper temperature. All residents will receive palatable meals at the proper temperature. Cooks were re-educated on taking temperatures and reheating when for the strength of the stren	g food
	R66's annual Minim 2/18/16, identified F	num Data Set (MDS) dated R66 had intact cognition, and ith eating after set up by staff.		not at the proper temperature prior to leaving the kitchen. Nursing staff has been re-educated on the dining proof for resident who receive trays. 4. Dietary Manager or designee will	o food ve

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F 364	stated she received because she didn't in the dining room, "Generally always of During observation 3/2/16, at 7:00 a.m toast, sausage link kitchen. CK-A cheusing the facility the french toast was 1-sausage links were was 158 degrees. serving pans, and brought to the four stated room trays of meal services, and (CDM)-A stated two were served their troom was served to a.m. dietary aide (Imeals to the reside A mobile cart was with trays and silved delivery, however, deliver to any resid a.m. nearly all of the had been served throom trays had been present during the dining room to retril 8:04 a.m. (42 minuarrived on fourth for room trays for residuarively or requested surveyor requested.	age 52 in 2/29/16, at 6:49 p.m. R66 id meal trays in her room like eating with other residents and stated her food was, cold" when served to her. If of the breakfast meal on cook (CK)-A prepared french s, and oatmeal in the facility cked the food temperatures ermometer and identified the do degrees (Fahrenheit, F), the entropy of the food was placed in metal placed in a steam table being th floor dining room. CK-A were served throughout the certified dietary manager or residents, including R66, rays first before the dining on help maintain the heat of the the steam table with the food the fourth floor, and at 7:34 DA)-A began to serve breakfast ents seated in the dining room. Claced next to the steam table erware set-up for room tray no food was put on to plates or ents in their rooms. At 7:49 the residents in the dining room their breakfast meal, and no ent delivered. CDM-A was meal service and left the eve the room tray orders. At tes after the steam table or), CDM-A started to prepare dents, including R66. The dia sample tray, and nursing took R66's covered meal tray.	F 364	conduct random weekly food tenthe kitchen prior to meal service. that food is not at the proper tem food will be reheated to the proper temperature to ensure that it is so and palatable. In addition, Dietar Manager or designee will conduct weekly test trays to ensure that for served hot and palatable x 4 week Results of audits will be reviewed for tracking and trending and QA will then adjust audit schedule accordingly.	If found perature, er erved hot ry trandom bod is eks.	

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	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		7505 COUN	ORESS, CITY, STATE, ZIP CODE TRY CLUB DRIVE /ALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORREC' ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 364	prepared at the sar requested, to R66 i served food on the oatmeal was 98 de 54 degrees, and the and the food on the 8:11 a.m. R66 had which had been pre requested sample to toast, "Isn't warm" a arrived in the room tray. NA-G stated to and she would, "Go. When interviewed stated the nursing sthe room trays, and should be served firemains warm. NA busy today" and un however, adding it, stated he was unsured when he served it to kitchen['s] responsionally responsionally responsionally responsionally the meals to reside "Didn't happen" as should have been served. To help hold temper complaints from he cold. The nursing sthe meals to reside "Didn't happen" as should have been service. Furth "On-going problem and their support would have been service.	ne time the sample tray was in her room. DA-A temped the sample tray, and stated the grees (F), the french toast was e sausage was 95 degrees, tray felt cold to the touch. At been served her meal tray epared along with the ray, and R66 stated her french and her food was cold. NA-H and observed R66's room he french toast was, "Ice cold" o grab another tray" for R66. on 3/2/16, at 8:27 a.m. NA-G staff were responsible to serve two residents, including R66, rest to make sure their food-G stated the staff were, "Very able to serve them first "Happens sometimes." NA-G re how hot R66's food was other because, "That is the	F3	64			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364 F 371 SS=E	residents a pleasur offering nutritious, a resident room wher directed staff to ser not identify when roduring the meal ser palatability or direct temperature before 483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	y, "Strives to provide all able dining experience by attractive meals served in the required." The policy we room trays covered, but did som trays were to be served vice to maintain heat and staff to check the serving the prepared food. ROCURE, (SERVE - SANITARY)	F 36			4/12/16
	by: Based on observate review, the facility for based product was to reduce the risk of potential to affect 1st the facility as who consumed the food. Findings include: An initial tour of the on 2/29/16, at 12:55	NT is not met as evidenced cion, interview, and document ailed to ensure left-over fish discarded in a timely manner f food borne illness. This had 5 of 15 residents identified by could have potentially . facility kitchen was completed 5 p.m. with certified dietary and registered dietician		1.Left-over fish product was immediscarded and coolers were inspect determine there were no other food products that needed to be discard 2.Facility staff were re-educated on for discarding leftover refrigerated in 3.Dietary Manager or designee will conduct weekly audits of coolers for proper discarding of leftover items weeks. Audits will be reviewed at Comeeting and QAPI team will adjust schedule appropriately based on fire	ted to led. policy tems. r x 4 API audit	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		03/	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	underneath a meta stated was a, "Nour prepare foods for re hours. A one gallor brown colored food labeled, "Tuna Sala "02-23-16" (six day container was appr with saran wrapping the cooler, including available for reside salad should have leadys." On 3/1/16, at 2:20 g culinary manager (of tuna salad had bee "Whoever wanted if any residents had restated the facility pofood after three day in the cooler was an stated the left-over food" and could cau it was consumed af Further, CDM-A stathe one gallon cont to make, "About 15	tour, a cooler was reviewed lic serving table which RD-A rishment area" used to esidents in between meal in plastic container of light was in the cooler which was id," with a date written, is prior) in black marker. The oximately 1/2 full and covered gr. RD-A stated the foods in grithe tuna salad, were introduced after,"Three oximately 1/2 full and covered gr. RD-A stated the foods in grithe tuna salad, were introduced after, "Three oximately 1/2 full and covered gr. RD-A stated the foods in grithe tuna salad. The introduced after, "Three oximately 1/2 full and covered gr. RD-A and complete tuna salad. CDM-A oximately 1/2 full and covered gr. and would have been used if equested tuna salad. CDM-A oximately was to discard left-over gr., and leaving the tuna salad in oversight by the cook. RD-A tuna salad was a, "Higher risk use potential food poisoning if ter three days of being made, ted the amount remaining in ainer was enough tuna salad [sandwiches]", and again the been discarded after three	F 37			
F 412 SS=D	7/2015, identified a labeled with the iter then "Discard refrig	or Storage policy dated Il leftover items should be in name and date of storage, erated leftovers after 3 days." E/EMERGENCY DENTAL	F 41	2		4/12/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	SURVEY PLETED
		245186	B. WING			03/0	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	an outside resource §483.75(h) of this provered under the state of dental services to making appointment transportation to an must promptly refer damaged dentures This REQUIREMENT by: Based on interview facility failed to coorservices for 1 of 3 making sinclude: R110's quarterly Minterview facility failed to coorservices for 1 of 3 makes and for the since of daily living grooming, bathing, independent with eactivities of daily living grooming, bathing, independent with eactivities of daily living for the since of daily living for the since of daily living grooming, bathing, independent with eactivities of daily living for the since of daily living for the	must provide or obtain from e, in accordance with art, routine (to the extent State plan); and emergency neet the needs of each ecessary, assist the resident in ats; and by arranging for d from the dentist's office; and a residents with lost or to a dentist. NT is not met as evidenced and document review, the redinate dental care and esidents (R110) reviewed for	F 4	.12	1.R110 was evaluated by nursing a scheduled for non-emergency dent on 4/7/16. 2.All residents have been reviewed potential dental needs, and referral been completed as indicated. 3.All staff will received education regarding the policy for routine and emergency dental services. 4.Social Services will continue to of dental services with admissions, ar review on a quarterly basis for routi services. Caring Partners will conduce weekly audits with residents regard dental service requests. Results of audits will be reviewed at QAPI for tracking and trending.	for s have	

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		03/	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 412	brush his teeth. Dur 3/3/16 at 12:16 p.m assistance with action brushes his teeth in Review of the Asso (ACP) of 7/31/15, ic food doesn't taste rathe ACP note from resident expressed though it has gone The progress notes service (SS)-B indicate be seendental."	ring a subsequent interview on, NA-B stated (R110) required vities of daily living but does dependently. ciated Clinic of Psychology dentified (R110) stated that "ight, kinda like its spoiled". 9/21/15 also identified the that food tasted poorly, "as bad, or having a bad taste." of 1/18/16 indicated social cated R110 was "put on list to 3/3/16, at 10:12 a.m. with	F 41	2		
F 425 SS=B	not seen the dentisin January 2016. She the dentist in 7/2014. During interview on stated that she had R110 during care of an appointment in fischedules were rewith SS-B and HUC not been on schedule stated that social sees schedule ancillary sconference and as 483.60(a),(b) PHAF ACCURATE PROC	ator (HUC)-A stated R110 had to even though he was referred the stated he was last seen by 4, over 1/1/2 years ago. 3/3/16 at 4:49 p.m., SS-B reviewed dental status with conference and had scheduled collow up. Resident dental riewed for 2/16, 3/16, and 4/16 candering this time. R110 had alle for a dental exam. SS-B revices was responsible to services during care needed, but this was missed. RMACEUTICAL SVC - REDURES, RPH Devide routine and emergency alls to its residents, or obtain the ement described in	F 42	25		4/12/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG		E SURVEY IPLETED	
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	PROVIDER OR SUPPLIER I VALLEY REHABILIT	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	<u> </u>		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	unlicensed personr law permits, but on supervision of a lice. A facility must prov (including procedur acquiring, receiving administering of all the needs of each of the facility must er a licensed pharmace.	part. The facility may permit nel to administer drugs if State ly under the general ensed nurse. ide pharmaceutical services res that assure the accurate g, dispensing, and drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation e provision of pharmacy	F 42	25			
	by: Based on observareview, the facility for solution available for not expired. This has residents or staff wexpired solution. Findings include: On 3/3/16, at 12:16 storage room was operactical nurse (LP room contained an Purified Protein Detest for exposure to date written on the "1-13-16." LPN-Bs	NT is not met as evidenced tion, interview, and document ailed to ensure tuberculin or resident and staff use was nad potential to affect 4 of 4 tho could have received the opened with licensed N)-B. A refrigerator inside the opened package of Tuberculin rivative (a medication used to o Tuberculosis) which had a box in black marker of, stated the tuberculin solution esident and staff. LPN-B		1.Facility has destroyed the solution labelled 1/13/16. 2.All opened tuberculin solution been audited and are currer manufacturer guidelines for 3.Nurses will be educated opolicy for medication storage recommendations. 4.DON or Designee will comweekly audits to ensure projectorage x 4 weeks. Results be reviewed at QAPI meetin and trending. QAPI team will audit schedule accordingly tidentified.	tions have ntly within usage. n following e nplete random per medication of audits will ng for tracking Il then adjust		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING			03/03/2016	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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	approximately four it should have been being opened on 1/ all of the staff were refrigerator for expinowever, she was a specific system to expecific system to expecif	g solution was enough for doses to be administered, and discarded after 30 days from 13/16. Further, LPN-B stated responsible to check the red medications and solutions, unaware if the facility had a ensure expired medications 3/3/16, at 3:44 p.m. nsultant (RNC)-A stated the should have been discarded for thirty days because the eness could be decreased. jectable Medications g, "Storage " identified tuberculin solution of when opened and discard r 30 days [underlined]." ng pharmacist was contacted as during the survey, but was ed for interview. EGIMEN REVIEW, REPORT	F 4			4/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/0	3/2016
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ige 60	F 428			
	by: Based on interview facility failed to ensidentified irregularit for effectiveness of for 1 of 5 residents unnecessary medic. Findings include: R66's annual Minin 2/18/16, identified if frequent episodes of scheduled and as medications. R66's signed physical identified orders for y"Fentanyl C2 [core] [micrograms per hochange every 72 hochange eve	cation use. num Data Set (MDS) dated R66 had intact cognition, of pain, and received needed (PRN) pain cian orders dated 2/3/16, rethe following narcotics: ntrolled drug] 25 mcg/hr our] Apply 1 patch and ours," and mcg/hr Apply 1 patch and ours," and c2 10 mg [milligrams] 3 g] by mouth every bedtime," arcotic pain medication] 5 mg ablets] [5-10mg] by mouth		1.R66 drug regime has been revie and updated as indicated. 2.All residents with PRN pain medit have been reviewed to identify poteriregularities with dosing and monit for effectiveness. 3.Nurses have received education regarding documentation requirem PRN Pain medication usage and monitoring for potential dosing irregularities. Pharmacy Consultan included in education relating to not lack of effectiveness and dosing of narcotics. 4.DON or designee will complete reweekly audits for documentation and clarification of potential irregularitied dosing and monitoring for effective prn pain meds x 4 weeks. Results audits will be reviewed at QAPI meter for tracking and trending. QAPI teathen adjust audit schedule according the trending identified.	cations ential coring ents for t was ting andom nd s with ness of of eeting m will	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		03	/03/2016	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 428	during the month. documentation to do ordered 5 mg dose needed narcotic m PRN (as-needed) / Sheet (tool used to effectiveness of ad 1/1/16 to 1/31/16, i date and time of ad and numerical rating and follow-up to the However, all of the R66's records. -MAR dated 2/2010 doses of the as-ne before the order was transcribed whim gi-ii [1-2 tablets] four hours] PRN' adoses of the as-ne However, there was determine if R66 re or 10 mg dose of the medication. PRN (/ Pain Flow Sheet didentified spacing the provided medication administration, pair rating, the medication had be been provided the	However, there was no determine if R66 received the e or 10 mg dose of the as edication. R66's Analgesic Record / Pain Flow monitor pain and medication ministered medication) dated dentified spacing to record the dministration, pain descriptioning, the medication provided, e provided medication. See fields were left blank on the edication of th	F 42	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			03/03/2016	
	PROVIDER OR SUPPLIEF	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 428	registered nurse (complaints of pain [medications] to he scheduled narcotic narcotic medication two tablets of as-nany tablets of the medication to provided and it's ean Analgesic Record medication was account was not aware of a would be document interventions, more as-needed narcotic Analgesic Record, reviewed the Januarecords and stated effectiveness comparcotic medication written here," and use it each time." unable to determine needed narcotic medication with the medication written here, and use it each time. Unable to determine R66 received During interview of assistant directors were expected to to document a reseffectiveness more supposed to use the stated she did not writing range order	on 3/3/16, at 10:48 a.m. RN)-E stated R66 had chronic and, "is on a couple of meds elp with that," including as in addition to as needed n. R66 had orders for one to eeded oxycodone for pain, and sed a pain scale to identify how as needed narcotic ride to R66. RN-E stated the d be recording the dose ffectiveness on the PRN each time a as-needed pain diministered. RN-E stated she any other location the staff enting their non-pharmacological ditoring or follow-up of the comedication than on the PRN "not that I'm aware of." RN-E ary and February analgesic of there was no monitoring of the pleted for R66's as needed nuse, "It should have been staff, "Need to be re-taught to Further, RN-E stated she was ne how many tablets of the as needed narcotic. In 3/3/16, at 12:56 p.m. the of nursing (ADON) stated staff use the PRN analgesic records ident's pain, and the itoring for it, "[They're] hat sheet." Further, RN-B think physicians should be refered to the total one to two tabs) at that was banned a long time.	F 4	128			

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245186	B. WING _		03/0	03/2016
	PROVIDER OR SUPPLIER VALLEY REHABILITA	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	On 7/16/15, no irregular 8/13/15, no irregular 9/7/15, no irregular 10/14/15, no irregular 10/14/15, no irregular 11/14/15, no irregular 11/14/15, no irregular 12/19/15, no irregular 1/22/16, the pharma using the as-needed almost daily, however irregularities were incregularities were incregularities were incregularitied. Although R66 had comedication, the facing identified the administ was effective and pain and the consult it was effective and pain and the consult incregular irregular The consulting pharmacist was required policy titled Consult pharmacist was required policy titled Consult incregular in the Med Administration in th	gularities were identified. On rities were identified. On ties were identified. On arities were identified. On acist noted R66 had been donarcotic pain medication for signed, "NI" for no dentified in the medication left, no irregularities were staff istered dose, and then instered medication to ensure necessary in managing R66's ting pharmacist failed to rity. The facility provided ants, which indicated "for ant recommendations, refer to the Review" procedure located tration Program. However,	F 4:	28		
F 431 SS=E	483.60(b), (d), (e) D	provided as requested. PRUG RECORDS, UGS & BIOLOGICALS	F 43	31		4/12/16
	The facility must en	nploy or obtain the services of				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/03/2016	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 431	of records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biologic labeled in accordance professional principal appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districted.	cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug or and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the cory and cautionary are expiration date when state and Federal laws, the all drugs and biologicals in ants under proper temperature it only authorized personnel to keys. Tovide separately locked, and compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to and other drugs subject to the facility uses single unit ibution systems in which the minimal and a missing dose can	F 431			
	by: Based on interview facility failed to ensity (transdermal narco	NT is not met as evidenced v and document review, the cure Fentanyl Patches otic patches) were destroyed v policies and procedures to		1.R66 medication administration r has been reviewed and updated to documentation and adherence to transdermal narcotic patches desti	include	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		03/	03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	reduce the risk of of (R66) reviewed for This had potential it R147, R65, R111) current orders for Findings include: A facility provided to Patche(s) listing identified R66 had C2 [controlled substant hour] Patch A every 72 hours," ar Patch Apply 1 patch identified nursing spatch down toilet for must witness." R66's medication ad dated 2/2016, identified nursing spatch down toilet for must witness." R66's medication ad dated 2/2016, identified nursing nurse Fentanyl patch by space to record which disposed of the old [initials]", and "NUF staff to have two nudestruction as direct R66's MAR identified changes occurred, times indicated two indicate the disposed of the old control in the struction as direct R66's MAR identified hanges occurred, times indicated two indicate the disposed of the old control in the struction as direct R66's MAR identified hanges occurred, times indicated two indicates the disposed of the old control in the struction as direct R66's MAR identified hanges occurred, times indicated two indicates the disposed of the old control in the struction as direct R66's MAR identified hanges occurred, times indicated two indicates the disposed of the old control in the struction as direct R66's MAR identified hanges occurred, times indicated two indicates the disposed of the old control in the struction and the struct	diversion for 1 of 5 residents unnecessary medication use. to affect 4 of 4 residents (R66, residing in the facility who had Fentanyl patches. Undated titled Fentanyl entified R66, R147, R65, and orders for Fentanyl (a narcotic	F 4:	2.All residents receiving trans narcotic patches medication administration record has been and updated. 3.Nurses have received eduction following policy for transderm patch destruction. 4.DON or designee will compare weekly audits for 4 weeks to appropriate transdermal nare destruction. Results of audits reviewed at QAPI for tracking trending. QAPI team will then schedule accordingly to the tridentified.	en reviewed cation on cal narcotic collete random ensure cotic patch will be g and adjust audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	be signing off they we patch destruction, "mark you saw it." F 2016 MAR and stat RN-E stated two not the destruction to e of correctly, and to medication isn't bei removed patches s dosage on it." During interview on registered nurse corremoved transderm have a second nurse destroyed correctly patches, "Still could [of medication]."	N)-E stated two nurses should witnessed the transdermal Both [nurses] are supposed to RN-E reviewed R66's February ed, "People aren't doing it," urses should be signing off on insure they are being disposed ensure the narcotic ing diverted because the till, "Have partial [medication] 3/3/16, at 12:34 p.m. insultant (RNC)-A stated the inal narcotic patches should se sign off to make sure it was because the removed I have some potential residue in insultant was contacted for	F 43	31		
	A facility Destruction dated 7/2015, ident patches should be removal, and "Two the destruction of the	nes during the survey, but was ed. n of Controlled Drugs policy ified used transdermal destroyed following their licensed nurses must sign for ne used patch on the on Administration Record				
F 465 SS=E	E ENVIRON The facility must pro	ovide a safe, functional, ortable environment for the public.	F 46	65		4/12/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/03/2016	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	00/0	0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Continued From pa	nge 67	F 465			
	by: Based on observar review, the facility of a hazard-free outsidesignated smokin to affect 23 resident R18, R138, R83, R8109, R114, R75, R74, R39, R127, R residents, staff and outside patio. In admaintain a clean art residents (R90) who locomotion. Findings include: UNEVEN SURFACT R88's annual Minimal 1/15/2016, indicate R114's quarterly MR114 had intact cog R45's admission MR45 had intact cog During observation outside on patio are the building, there we electric-powered or were smoking. The approximately 10 fee	de patio area, used as a g area, which had the potential its who smoked (R56, R88, 115, R53, R169, R42, R170, R9, R10, R26, R129, R134, 95 and R25) as well as other visitors who utilized the ddition, the facility failed to not sanitary wheel chair for 1 of who utilized a wheel chair for E NEAR ENTRYWAY Thum Data Set (MDS), dated d R88 had intact cognition. DS, dated 12/21/2015, indicated gnition. DS, dated 2/5/2016, indicated		1.Areas of patio that is designated smoking area has been repaired eliminating unevenness from concressab to slab. R90's wheelchair arminas been replaced. 2.Public sidewalks have been inspeand repaired as necessary. All resignates wheelchairs have been inspected for being in proper repair. Any noted in disrepair have been corrected. 3.Facility staff have been educated notifying maintenance department issues with uneven patio areas/side and wheelchairs being in proper replay. Maintenance Director or designed conduct monthly audits of sidewalk identify any potential hazards. Maintenance Director or designed conduct random weekly audits of wheelchairs x 4 weeks. Results of wheelchairs x 4 weeks. Results of will be reviewed through QAPI com and QAPI team will adjust audit schas appropriate.	ete rest ected dent or on of any ewalks oair. e will s to will f audits mittee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING		03	03/03/2016	
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	marked with a worr the patio began. A downward from the area, was also mar painted stripe wher section of concrete the patio, and was from the patio towad difference in the he created a ridge on resident smoking a During a subseque there were again reseated in their whe with their walkers pindependently navig regular walker, and walker up slightly in the entrance of the propelled a standar reaching the patio a required a couple of the wheelchair of the surface was un seated in an electric the chair over the rill an interview on 3 stated she "has not the patio, but has so on the uneven ridge seen residents struridge with their indirected "I don't have	ard, led to the patio, and was any yellow-painted stripe, where nother sidewalk, sloping patio led toward the parking ked with a faded, yellow e it joined the patio. This was 1 1/2" (inches) lower than as wide as walk leading away and the parking area. The ight of these concrete sections the patio area, identified as a rea. In observation at 4:19 p.m., esidents who were smoking, el chairs, or on a bench chair, arked in front of them. R114 gated the patio area with a was observed to lift the order to go over the ridge to patio. R45 independently and wheel chair, and upon area, R45 backed up slightly, of attempts to push the wheels wer the ridge of the walk where even. R88 was observed a chair, as she maneuvered adge. 3/3/2016 at 3:20 p.m., R88 a seen anyone fall," outside on seen "people stub their toes" e. R88 also stated she had ggle to maneuver over the vidual wheel chairs. R88 also an issue" with the my power a potential for a problem	F 46				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/	03/2016	
	PROVIDER OR SUPPLIEF	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 465	R114 stated when supervised." R114 over the area that stated she had ne or trip on the pave tries to "not go be smoking." In an interview on registered nurse (I utilized by smoker it usually "levels be were "all kinds of including those who chairs "four-wheel and some who use non-smokers. RN assessed to be abability to be outsid residents required them during specified been no falls."	w on 3/3/2016 at 3:55 p.m., smoking "I have to be 4 stated she usually did not go is a different height. R114 ver fallen, nor seen anyone fall ment. R114 also stated she wond the striped area when 3/3/2016 at 3:58 p.m., RN)-I stated the concrete area is did shift, but that in the spring ack out." RN-I stated there residents" who used the area, no propelled their own wheel led walkers, regular walkers, is no assist devices," and also I stated residents were the facility. RN-I also stated if supervision, staff went with fic times. (RN)-I indicated there because of the uneven surface	F 46	,			
	to 3/3/2016 reveal incidents which reto the uneven surf. During an interview maintenance persaware of the uneventhe concrete would up in the spring. Twould be a concerthe slab away fron difficult for wheel of	incident reports from 10/1/2015 ed there were no resident sulted in falls or accidents due ace on the outside patio area. If you on 3/3/2016 at 4:58 p.m., the onnel (MP)-A stated he was en concrete area, and indicated drise when the ground come he MP stated he felt there in "if the ridge was higher on the building," making it more chairs to get over it. The MP lid not go down after spring,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING			03/03/2016	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	"then I will be trimm would also "re-mark as it relates to resign none was provided." BROKEN WHEELO BROKEN BROKEN BROKEN WHEELO BROKEN	arding maintenance of property dent safety was requested, but the safety was requested, but the company dent safety was least the wall. The company dent safety dent saf	F4	165			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/	03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, 2 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 465	maintenance perso they had not been r wheelchair, but wou R90 was not cut by A facility Wheelchai 7/2015, identified, " staff notices loose h safety issues with the the resident should potentially unsafe w	3/2/16, at 1:50 p.m. nnel (M)-A and (M)-B stated notified of R90's broken ald fix it immediately to ensure the broken plastic perimeter. It Safety Checks policy dated when clinical or non-clinical nardware of other possible ne operation of a wheelchair, be removed from the wheelchair, the wheelchair on, and the repair personnel	F 4	165		

PRINTED: 04/11/2016 FORM APPROVED OMB NO. 0938-0391

		(X3) DATE SURVEY COMPLETED			
		245186	B. WING		C 03/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	03/03/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT		F 00	0	
F 282 SS=D	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. A complaint investign the time of the stand H5186212, and was 483.20(k)(3)(ii) SEFPERSONS/PER CATTHE SERVICES PROVIDED TO THE SERVICES PROVIDE	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with gation was also completed at dard survey, complaint a unsubstantiated. RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of the accordance with the complete and followed for 2 of 3 l.5, R5) reviewed for pressure esidents (R5) dependent upon	F 28	1.R89,R5,R60's skin assessments of care, and nursing assistant care have been reviewed and updated a appropriate. R115 is not longer a re at the facility. 2.All residents with pressure ulcers assessed and plan of care and nurs assistant care guides reviewed and updated as indicated. 3.Nurses will be educated on	guides s sident will be sing
ARORATOR)	' DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

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

Electronically Signed

04/01/2016

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. DOILD	iiva _		(
		245186	B. WING			03/0	03/2016
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	have both heels float noted R89 was to he foot when in bed. The undated and undid not specify R89 nor did the sheet in foam boot on the rigskin noted staff were checks. Assist reside [as needed]." R89 was observed through 7:29 a.m. of be sleeping on his lidirectly on the matter foam boot on it. At (NA)-A was intervied have the heels float should have been for the right heel as the verified the NA sheef foam boot and to float the right heel as the verified the NA sheef foam boot and to float the information of the heels was not on the R89 did not receive promoted healthy significant in the significant conditions and the right heel as the verified the NA sheef foam boot and to float the information of the heels was not on the R89 did not receive promoted healthy significant conditions.	ated. In addition, the care plan have the "bootie" on the right intitled NA assignment sheet was to have the heels floated dicate R89 was to wear a ght foot. The section under re to "Q [every] shift skin dent with back scratcher PRN on 3/2/16, at 6:20 a.m. continuously. R89 was noted to back and both heels were lying ress. The right heel had a blue 7:29 a.m. nursing assistant and verified R89 did not ted. When asked if the heels loated NA-A indicated, "No." onsultant (RNC)-A was a.m. and verified R89 did not ted. RNC-A indicated R89 had ter on the right foot and it was d there was no treatment to be blister was intact. RN-A et lacked direction of the blue bat the heels. Indicated NA sheet. The computerized NA sheet. HUC-A acknowledged the blue boot and floating the ne computerized NA sheet. The care and services that	F 2	282	implementing and following wound protocol for residents with pressure ulcers, including completing and documenting treatments. Nursing will be educated on following interv for pressure ulcer prevention and residents with pressure ulcers, incluturning/repositioning and using preselieving devices or techniques. 4.DON or designee will complete raweekly audits to ensure staff follow plan of care for residents at risk for altercation, including toileting and repositioning, for 4 weeks. Results audits will be reviewed at QAPI for tracking and trending. QAPI team vadjust audit schedule accordingly to trending identified.	staff entions uding ssure andom s the skin of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			C / 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	<u> </u>	700/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	identified a well de and implements ar based on the asse. Pressure Ulcer Tre Physician Orders On 3/2/16, at 8:41 R115 pressure ulce had two ulcers one was beefy red, with showed no signs o practitioner stated R115's Skin Integri Treatment Care Pland a pressure ulcer to the provide treatment provide treatment provide treatment of the wound medial buttock following the wounds. The February 2016 treatment to cleans skin prep and covereviewed. 7 days in left blank and 4 day when interviewed stated R115 is sup change to the sacre the wound physicial Wednesday. RN-G is not always done	veloped care plan develops in interdisciplinary care plan interdisciplinary care plan issment information gathered. It is at ment Not Completed per a.m. with the nurse practitioner is were observed. The coccyx is above the other wound bed nout drainage, odor and if infection. The nurse interest were healing nicely. It is a session of the session of the session of the session of the plant of t	F 2	32		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			C 03/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, S' 7505 COUNTRY CLUB DE GOLDEN VALLEY, MN	RIVE	00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
F 282	treatment sheets in if not marked the tro R60's Skin Integrity Treatment Care Plapressure ulcer to the staff to provide treatment or daily apply Sawith foam dressing the right ischium. On 3/3/16, at 9:27 a observation of prest treatment to cleans cover with non adhord Three out of five day documented as corone out of five days. The February 2016 treatment to cleans cover with adhesive of 28 days the treatment to cleans cover with adhesive of 28 days the treatment to cleans cover with adhesive of 28 days the treatment to cleans cover with adhesive of 28 days the treatment to cleans cover with adhesive of 28 days the treatment documentation and documented as refull when interviewed as refull when interviewed as refull when interviewed as the deveryday. R60 further treatment of the first provided that the nurse every day but the deveryday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday. R60 further treatment of the first provided that the nurse everyday.	dicated resident refusals and eatments were not completed. Assessment: Prevention and an dated 1/16, indicated a e right ischium and directed timent per MD order. dated 1/27/16, directed staff to ntyl, apply skin prep and cover to Stage III pressure wound to a.m. R60 refused surveyor sure ulcer. reatment record for the daily e wound apply Santyl and esive foam was reviewed. Lys the treatment was not impleted and was blank and a marked as refused. treatment record for the daily e and treat with Santyl and e foam was reviewed. Nine out ment was not documented as a blank. Seven out of 28 days ed without any follow up one out of 28 days were	F 2	82		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	COV	E SURVEY MPLETED
		245186	B. WING _		I	C / 03 / 2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		90,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	When interviewed stated that R60 had her coccyx and it dordered because the further stated shern the dressing was not be with the dr	on 3/3/16, at 3:38 p.m. RN-d wound care ordered daily to loes not get done everyday as ne facility is short staffed. RN-reports off to the next shift that ot completed. on 3/3/16, at 3:50 p.m. RN-nd care be completed as er stated she has been told by s that the wound care did not ift. RN- stated she tells the n to the next shift. RN- further a staffing is not adequate to get on 3/3/16, at 5:43 p.m. RNC-A call treatments to be done	F 28	32		
	1/6/16, indicated the cognitive impairme for all activities of calso identified diage hypertension, perip	mum Data Set (MDS) dated be resident had severe ent, and was dependent on staff daily living (ADL's). The MDS noses of quadriplegia, oheral vascular disease, and efunction of the bladder.				

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COV	(X3) DATE SURVEY COMPLETED		
		245186	B. WING			C / 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	identifies a risk of a mobility and bowel directed to turn, reincontinence every undated work list of position R5 every the stool and was to be two hours. On 3/2/16, R5 was 6:21 a.m. to 8:28. A his back in bed wit 7:06 a.m., respirate room to perform recontinued to remain back, RT-A comple exited the room. If was not repositioned during this time. At same backlying possistant (NA)- Be the surveyor that rewere provided by the a.m., more than 2. The day shift staff assistance with inchim up for breakfar was incontinent of R5's skin had two buttocks, near rectarea of soft, white, covered with white pink underlying tiss an area of macera that measured app 1 cm in width whice	re plan updated 1/15/16 skin breakdown with impaired incontinence. Staff were position, check and change for 2 hours. Review of the NA lirects the staff to turn and two hours, was incontinent of 2 checked and changed every cobserved continuously from at At 6:21 a.m. R5 was lying on the pillow on the right side. At cory therapist (RT)-A entered aspiratory cares. At 7:35 a.m., in in the same position on his eted the respiratory cares and as remained on his back, and ed nor was peri care performed as:18:a.m. R5 remained in the sition. At 8:28 a.m. nursing entered the room, and informed outine personal morning cares the night shift staff before 6:00 hours and 28 minutes earlier. Were responsible to provide R5 continence care prior to getting st. NA-B provided pericare, R5 a soft stool during this time. arge areas on his right and left um that was macerated, (an deteriorating skin), which was barrier cream with areas of sue exposed. There was also tion under the right gluteal fold proximately 2 cm in length and in had a build up of sloughed of the maceration, with bright	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309 SS=G	NA-B stated this ar and she would let to R5 was observed in a.m. seated in his whe continued to be a.m. NA-B and NA with the mechanica was last provided was last provided was last provided was incontined. During interview or stated that she word different shifts and reposition him ever buttocks and to che every two hours. 483.25 PROVIDE CHIGHEST WELL BEach resident mus provide the necess or maintain the higmental, and psychological.	sue present (skin was intact). rea (right gluteal fold) was new he nurses know. In his room, on 3/3/16, at 9:44 wheelchair (w/c). At 10:11 a.m. in the same position. At 10:16 -A were assisting R5 into bed al lift. NA-B stated that (R5) with pericare this morning at 2 hours and 31 minutes JA-B provided pericare to R5, not of soft stool. In 3/3/16 at 5:10 p.m., NA-J, rks with R5 routinely on was aware to turn and my 2 hours, so he was off his eck for bowel incontinence	F 2			4/12/16	
	by: Based on observa review, the facility the interventions to reco	NT is not met as evidenced tion, interview and document ailed to implement luce skin irritation and 2 residents (R5, R23)		1.R5 and R23 skin assessmen care, and nursing assistant care have been reviewed and update R86 is no longer a resident at t	e guides ed.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU		COM	SURVEY PLETED			
		245186	B. WING		03/0) 3/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 309	reviewed for non-p This resulted in ac moisture associate when interventions addition, the facility an outside dialysis (R86) reviewed for Findings include: NON PRESSURE R5's quarterly Mini 1/6/16, indicated the cognitive impairmed catheter, was alwadependent on staff (ADL's). The MDS quadriplegia, hypedisease, and neuro bladder. During interview or registered nurse (Fof moisture associate left buttocks mades and one of cm x 5 centimeters. On 3/2/16, R5 was 6:21 a.m. to 8:28 and on his back in bed At 7:06 a.m., respiroom to perform re R5 continued to re his back, RT-A cor and exited the room and was not repos	oressure related skin conditions. It was a related skin conditions. It was a skin damage became worse is were not implemented. In a failed to collaborate care with agency for 1 of 1 residents or dialysis.	F 309	2.All residents with non pressure reskin alterations will be assessed, page care and nursing assistant care greviewed and updated. All resident receiving dialysis services will be to ensure collaboration/communic between dialysis and SNF. 3.Nurses will be educated on propolicies/procedures for residents valterations including assessing & documentation, implementing interventions, and monitoring residents with skin alterations. They will also educated on dialysis collaboration/communication. Nursitaff will be educated on following interventions for preventing skin alterations including repositioning incontinence care. 4.DON or designee will complete tweekly audits to ensure interventioned being implemented for residents where the pressure related skin breakdown from tweeks. DON or Designee will audic communication between SNF and center weekly is being completed weeks. All audit results will be reviously to trending identified.	plan of vides ts reviewed ation er with skin dents be sing and random or 4 t dialysis for 4 ewed at API	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		C 03/03/2016	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00	35/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	a.m. nursing assist and informed the s morning cares were staff before 6:00 a. minutes earlier. The responsible to provincontinence care purcential breakfast. NA-B princontinent of a sof skin had two large buttocks, near rectarea of soft, white, covered with white pink underlying tiss an area of maceral that measured app 1 cm in width which mass of dead tissu maceration, with bropresent (skin was in the staff of the s	me backlying position. At 8:28 ant (NA)- B entered the room, urveyor that routine personal re provided by the night shift m., more than 2 hours and 28 e day shift staff were ide R5 assistance with prior to getting him up for rovided pericare and R5 was t stool during this time. R5's areas on his right and left um, that was macerated (an deteriorating skin), which was barrier cream and areas of the exposed. There was also ion under the right gluteal fold roximately 2 cm in length and in had a build up of slough (a e) to the side of the right pink underlying tissue intact). NA-B stated this area was new and she would let the	F 309	9		
	wound care medica RN-B to evaluate to buttocks with the state assessed the area the macerated area associated dermation the right gluteal over the ischial tub macerated. RN-B of the new area of until now. MD-A rea provide "careful and	s p.m. R5 was seen by the al doctor (MD)-A and the macerated areas on his urveyor present. MD-A on R5's buttocks and stated as were "incontinence tis with excoriations." The area fold was an "old healed ulcer erosity" that was becoming stated that she was not aware maceration on the gluteal fold commended to RN-B to d meticulous hygiene" iter protection to these areas.				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245186	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505 C	T ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427	1 00/1	55/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	During a subseque stated R5's skin hat to 6 and that incon alkaline and can estated that treatme incontinence assorprovision of perica cream, and monitor on 3/3/16, at 9:44 room seated in his a.m. he continued 10:16 a.m. NA-B a bed with the mech (R5) was last proviat "about 7:45 a.m earlier). NA-A and who was incontine in the room at the of the three macer measured 8 cm x (and right gluteal for stated all three are increased in size fit taken on 2/21/16. Review of progress R5 had an open are the right buttocks 7 x 4.5 cm "open does not lood dressing changes. progress notes did measurements, or R5's macerated sk. Review of the physical stated all three are increased in size fit taken on 2/21/16.	ent interview at 1:34 p.m., MD-A as an acid mantle of about 4.5 tinence, especially stool, is asily excoriate the skin. MD-A ent recommendations for ciated dermatitis included re, application of a barrier oring of the area. a.m. R5 was observed in his wheelchair (w/c). At 10:11 to be in the same position. At and NA-A were assisting R5 into anical lift. NA-B stated that ided with pericare this morning." (2 hours and 31 minutes NA-B provided pericare to R5, nt of soft stool. RN-B, who was time, obtained measurements ated areas. The right buttock of cm, left buttocks 9 cm x 6 cm old 2.5 cm x 2 cm RN-B as of macerations had from previous measurements. In notes 2/21/16 identified that rea on bilateral buttocks with measuring 7 x 5 cm and left m The note indicated that the note indicated that the note indicated that the note indicated that not identify any monitoring, a comprehsive assessment of	F3	509			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	peri-rectal area rec inflammation, need with nursing staff." care physician) pro identified the the diassociated dermati "meticulous hygiend protection." Review of R5's cardidentified a risk of smobility and bowel directed to turn, repincontinence every directed staff to appear to the wand to update the partner was no evide. Review of the undastaff to turn and posincontinent of stool changed every two progress notes of bidentified the need pericare" and barried plan, nor the work I. During interview on stated she had not on 2/24/16, with MI recommendation to barrier protection for some interventions that new diagnosis from 2/24/16, and th "meticulous" perica	ently, mild peri-rectal skin better pericare, discussed A review of MD-A's (wound gress notes of 3/2/16, agnosis of incontinence tis and the need for e combined with barrier e plan updated on 1/15/16, skin breakdown with impaired incontinence. Staff were position, check and change for 2 hours. The care plan also bly barrier cream to peri area round weekly and as needed, shysician within two weeks if	F3	309			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00/	00/2010
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F 309	identified in the medays earlier. During interview on stated that she word different shifts and reposition him ever buttocks and to che every two hours. Not directed to provide because of R5's sk different skin barrie at the beginning of directed the staff to skin concern." Even though R5 was activities of daily livincontinent of bowe of skin maceration. (MD-B) and the word (MD-A) identified the and barrier protection timplemented are had increased in six developing in the poin actual harm for FA procedure, titled: Management, effect Turning and Repose who are unable to tindependently. This minutes before or 1 predetermined time individualized turnir using: Skin Integrity	dical record on 2/21/16, 11 3/3/16, at 5:10 p.m. NA-J ks with R5 routinely on was aware to turn and y 2 hours so he was off his eck for bowel incontinence A-J indicated she was not pericare more frequently in concerns, or to use a r. NA-J stated, "We get report each shift, and no one has do anything different for [R5's] as dependent on staff for ing, and was frequently I and had two existing areas Both the primary physician und care medical doctor e need for better peri-care on. Theses interventions were noted the existing skin maceration ace, with an additional area eri gluteal fold which resulted ace; it occur between 15 5 minutes after the as "Communicate the and and repositioning schedule of Assessment; prevention and an, Care Deliver Guide/Nursing		309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 309	Continued From pa	ge 12	F3	809			
	diagnosis of heart f edema, and identificare. R23's annual identified R23 had s and the quarterly M R23 required extendaily living, and had present. During an observating and had present as a sitting in had near the nurse's stallower extremities. Review of R23's Sk Insufficiency Ulcer/6	cord dated 9/30/15, included ailure, chronic kidney disease, ed R23 was receiving hospice MDS dated 10/12/15, severe cognitive impairment, DS, dated 1/13/16, identified sive assistance for activities of I no venous or arterial ulcers ion on 3/2/16, at 1:32 p.m. his wheelchair in the hallway ation with wraps noted to both cin Grid-Pressure/Venous Other forms, completed for					
	were present on ad "excoriation," and he red, foul odor drains wound was 30 cm (cm in width, and the was 45 cm in length were no additional substitutional substitution of the red in the form directed staff that assessments, and width, depth, color of tunneling/undermin were blank.	to include the date, length, of drainage, color, odor, ing with depth, both forms					
	for R23 dated 11/25	y EHSI Skin Assessment form 5/15, identified a picture of the of a body with hand drawn					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONST	(X3) DATE SURVEY COMPLETED			
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F 309	lines and arrows to wounds, weeping le An Admission Skin included hand draw with, "cellulitis" writt were no further skir for R23's bilateral lo Review of R23's Conserview Summary, 1/19/16, under Skin skin/wound issues at the record review in treatments to his bing Skin Integrity Assest Treatment Care Pla "Lymphedema BLE edema [with] weeping Review of progress 2/21/16, identified Fand treatment application, color bilateral lower legs notes. The 2/22/16, [resident] legs are convoided were so soak drainage they were were no additional appearance of R23 from 2/23/16 until 3/2/22/16, notes idense smell" and socks and drainage. R23's physician's o "Bilateral lower ext	both lower legs, with "weeping egs" written beside the picture. Assessment dated 1/7/16, on marks on both lower legs een beside the picture. There is assessment forms identified ower extremities. Imprehensive Care Plan dated 10/20/15, 1/7/16 and Included, "No since last review." However edicated R23 had ongoing lateral "weepy" legs. R23's esment: Prevention and en, dated 1/7/16, included, [bilateral lower extremity] ing." Is notes from 11/3/15 through R23's legs were clean, dressed ed. There was no mention of drainage, or odor of R23's until the 2/22/16, progress progress note identified, "Res	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING				03/ 2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	1 00/1	56/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	both legs and feet, red stripe) tubular toes to 1 inch below Administration Received to complete this tree. During an interview stated she was unsubseen "weeping", she since December 2 assessment and mextremity "weeping the nursing progre. Administration Received location, size, drain description of the a RN-H stated, "The what we are assess expectation." Review of R23's Trand 2/16, lacked do or monitoring of R2 to determine if they buring interview or stated R23's legs a cleaned, dried and on the areas. The absorbent dressing fluid), because the then wrap the area ankles. Although R23 currelower extremities a day, and being treasured and Atrace Bacitracin and Atrace.	cover with edema wear (large, compression stocking from w knee." R23's Medication cord dated 2/16, directed staff eatment twice daily. I on 3/3/16, at 10:11 a.m. RN-H sure how long R23's legs have he has only been at the facility 015. She also indicated the nonitoring of R23's lower graea" should be monitored in ss notes, and/or Treatment cord (TAR) at least weekly. The hage, color, odor, and area should be monitored. If [staff] should be documenting using, that would be my AR's dated 11/15, 12/15, 1/16, occumentation of assessment 23's bilateral lower extremities of were improving or not. In 03/03/16, at 11:22 a.m. RN-M are soaked twice a day, Bacitracin ointment is placed by use ABD pads (thick go that soaks up large volume of the re is so much drainage, and a with kerlix from his knee to the soaked and washed twice a dated with different ointments, actain. The facility has not bred R23's "weeping" legs, and or complete the soaked weeping legs, and or complete the soaked weeping legs, and or complete the soaked and washed twice a dated with different ointments, actain. The facility has not ored R23's "weeping" legs, and	F3	309			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED					
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F 309	skin condition for loperiwound condition symptoms of infecti if R23's legs were have treatment was effect. Review of the facilitiex tremity Ulcer Interest. The condition of the wound healing by depth of the wound include drainage/extunneling/undermin wound edges, anat and symptoms of intissue. Also include the wound treatmen weekly assessment. DIALYSIS R86's significant che (MDS) dated 2/10/1 cognition and received buring interview on stated she just starbeen hospitalized report in her chest the managing for her. When interviewed or registered nurse (R dialysis when she was a port on her RN-E stated the faccommunication body	cation, size, drainage, n, wound edges, signs and on, pain or odor to determine realing and if the current ctive for R23. By's procedure: Lower ervention and Treatment, dated to document the progression of measuring length, width, and and documentation should cudate, color, odor, ing, periwound condition, omical location, pain, signs affection, and wound base d, "Regardless of who is doing nt, Nursing Services will do the t." ange Minimum Data Set 6, identified R86 had intact wed dialysis services. 3/2/16, at 8:18 a.m. R86 ted dialysis when she had excently, and currently had a edialysis center was on 3/2/16, at 12:51 p.m. N)-E stated R86 started was recently hospitalized, and right chest wall for access. cility used a binder (a ok) to help manage R86's care and they send the binder with		809			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	dated 2/23/16, ider of eight dialysis tre clinic. An undated blank Record, a tool use care with the off-si The form used three	emodialysis Treatment record atified R86 had received a total atments at the off-site dialysis Dialysis Center Communication d to ensure collaboration of the dialysis clinic, was reviewed. The spaces for the facility and ocument pertinent results and	F3	09			
	nutrition, and medireviewed and identification. On 2/5/16, the facipre/post dialysis do dialysis nurse did r R86's treatment, in work, if any access condition, or how streatment even the patient. The space left blank. On 2/8/16, the facipre-dialysis documnurse and returning any information on the treatment since spaces to record the treatment complication. On 2/10/16, the facipre and post dialysis nurse did r R86's treatment, in R86's treatment, in the space of the second streatment, in the second streatment in the second streatment.	lity nurses completed R86's occumentation, however the not record any information on acluding any completed lab is complications, of changes in the tolerated her dialysis and R86 was a new dialysis is to record these items were lity nurse completed R86's entation, however the dialysis of facility nurse did not record record of how R86 tolerated as she was new to dialysis. The ne completed vital signs, attions, and any completed lab					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 309	The spaces to reco On 2/29/16, the fac pre-dialysis docume complete their docu returning facility nur documentation inclu symptoms of bleedi were present even dialysis patient. The was left blank. There were no treat 2/12/16, 2/15/16, 2/ although R86's Her identified she receiv When interviewed of stated staff are insti with [R86]" to her di everything pertaining "Stays in the binder dialysis communica and stated, "people RN-E stated the encompleted because communication tool clinic." This was the they not communica R86 even though sl During interview on dialysis nurse (DN) complete the record was, "Just not enous so. Further, DN sta	ility nurse completed R86's entation, and the dialysis nurse immentation. However, the rese did not complete any ading identifying if any signs or ang, low blood volume, or pain though R86 was a new expaces to record these items in though R86 was a new expaces to record these items in though R86 was a new expaces to record these items in though R86 was a new expaces to record these items in though R86 was a new expaces to record these items in though R86 was a new expaces to record these items in though R86 was a new expaces to record these items in though R86 was a new expace to record these items in the statement of the property	F3	309			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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Continued From pa	ge 18	F 3	09		
stated R86's dialysi (binder) was used f the facility and off-s "Supposed to be co	s communication book or communication between ite dialysis clinic and it was, ompleted" adding it was, "A				
had received eight coordination of care center and facility to	treatments, there was no e completed with the dialysis o ensure R86 tolerated her				
but none was provid 483.25(a)(2) TREA	ded. TMENT/SERVICES TO	F 3	11	4/12/16	
services to maintain	n or improve his or her abilities				
by: Based on observate review, the facility for assistance with eather residents (R90) revolving (ADLs). Findings include: R90's annual Minime 1/10/16, identified F	ion, interview, and document ailed to ensure timely ing was provided for 1 of 3 iewed for activities of daily num Data Set (MDS) dated R90 had severe decision		dining services has been reviewed updated 2.All residents requiring assistance dining services have been assessed plan of care reviewed and updated indicated 3.Facility staff will be educated on regarding residents requiring assis with eating.	e with ed and I as policy stance	
	Continued From particles of the facility and off-secondination of care continued and received eight coordination of care center and facility to dialysis runs which A facility policy on a but none was provided as 25(a)(2) TREA IMPROVE/MAINTA A resident is given to services to maintain specified in paragra. This REQUIREMENT by: Based on observator review, the facility fassistance with eat residents (R90) revilving (ADLs). Findings include: R90's annual Minimal 1/10/16, identified in paragra.	TOTALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 When interviewed on 3/3/16, at 1:09 p.m. RN-B stated R86's dialysis communication book (binder) was used for communication between the facility and off-site dialysis clinic and it was, "Supposed to be completed" adding it was, "A communication tool between the center and us [facility]." Although R86 was new to dialysis treatments and had received eight treatments, there was no coordination of care completed with the dialysis center and facility to ensure R86 tolerated her dialysis runs which started February 8, 2016. A facility policy on dialysis care was requested, but none was provided. 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS 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 ensure timely assistance with eating was provided for 1 of 3 residents (R90) reviewed for activities of daily living (ADLs).	PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER	PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETIX TAG PROVIDERS PLAN OF CORRECTIVE ADDRESS (EACH CORRECTIVE ADDRESS) PRETIX TAG PROVIDERS PLAN OF CORRECTIVE ADDRESS (EACH CORRECTIVE ADDRESS) PRETIX TAG	

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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILI	TATION AND CARE CENTER			505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311	from staff for eating R90's nutrition risk identified R90 was staff to, "Assist with identifying R90 recomplete [her] me During observations 8:08 a.m. R90 was other residents and food consisting cound a banana. Read and was trying to pher plate using the the fork using the the table. R90 the chest and closed hypractical nurse (LF gave R90's tablem offering assistance opened her eyes a her plate of food, swatching them eat again came to R90 tablemate who had table at 8:19 a.m. or encouragement R90 picked up a splate and took seven the piece of toast of table. At 8:29 a.m. came to R90's table food and offered the control of the R90. NA-D left offering any encouragement R90.	required supervision with set-up g. care plan dated 10/2014, at nutritional risk and directed h meals as needed," further juired, "Extensive Assist to	F3	311	weekly audits on residents requirin assistance with eating for 4 weeks audit results will be reviewed at QA tracking and trending. QAPI team adjust audit schedule accordingly trending identified.	All API for will then	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		245186	B. WING _			C / 03 / 2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 311	R90 opened her ey table at her tablem before lowering her closing her eyes ag since observation opulled up a chair to offered her assistathis?" NA-E helped glass of apple juice provided assistance good." NA-E proviuntil 9:10 a.m. whe table to help other all of her banana, a juices after being pfrom staff. When interviewed member (FM)-F state enough staff to hele eat, "I wish there we FM-F had visited Rand noticed R90 disat and cued her to would often play with incorrectly to eat. During interview or stated R90 would a eating, but staff we assist her with all now wait for assistance staff in the dining ree at at the same time help."	age 20 onto her chest. At 8:37 a.m. ves and looked around the ates and the food on her plate, in head back onto her chest and gain. At 8:49 a.m. (41 minutes of meal service began) NA-E the right side of R90 and ince, "Shall we have some of d R90 pick up and hold a full e, peeled the banana, and e to eat; R90 stated, "That's ded R90 assistance with eating in NA-E stood up and left the residents. R90 had consumed and nearly all of her toast and provided assistance with eating on 3/1/16, at 1:38 p.m. family ated she did not feel there was a p R90 and the other residents as more help at meal times." (190 before during meal times and the eat well unless someone of do so, and FM-F stated R90 and the residents are refuse assistance with the silverware or use it at 13/2/16, at 9:23 a.m. NA-F at times refuse assistance with the supposed to attempt to neals. NA-F stated R90 had to because their was not enough from the light of the residents are, and stated, "We need more on 3/2/16, at 11:29 a.m. RN)-C stated staff should be	F 31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION NG	COMPLETED
		245186	B. WING _		C 03/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLÉTION
F 311 F 312 SS=D	offering assistance they notice she is n are] supposed to as A facility policy on e requested, but none 483.25(a)(3) ADL C DEPENDENT RES A resident who is undaily living receives	and cues to R90 for eating if ot eating on her own, "[Staff esist her, or try to." eating assistance was e was provided. EARE PROVIDED FOR	F3		4/12/16
	by: Based on observat review, the facility for ambulation services or maintain the resi of 1 residents (R84 Findings include: R84's quarterly Min 1/7/16, identified R8 impairment, require transfers, physical a was on a restorative R84's Therapy Rec Restorative Program staff were to ambul	ommendations for a m dated 10/23/15, identified ate with the resident three a wheeled walker from his		1.R84 has been re-assessed for restorative ambulation and plan of and nursing assistant care guides been updated. 2.All residents with recommended restorative ambulation plans have reviewed to ensure their program careplanned and communicated on nursing assistant care guide. 3.Nursing staff will be educated or careplanning restorative ambulation programs on the nursi assistant care sheet, and ensuring programs are being followed. 4.DON or designee will complete tweekly audits to include restorative ambulation programs being carep and communicated on the nursing assistant care sheet and programs	been is on the tive ng g random e lanned

AND DIAN OF CODDECTION INDESTRUCTION NUMBER.		E CONSTRUCTION	COM	E SURVEY PLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	R84's care plan dat to provide assistant room, and R84 requive wheelchair for mobidentify staff were to meals. No restorative flow ambulation for R84 When interviewed of medication aid (TM self-propel the wheelchair to the whe	ced 10/15, identified staff were be to and from the dining uired a cane, walker, or ility. However, it did not assist with ambulation to sheets were available for assist with ambulation to sheets were available for an 3/2/16, at 11:43 a.m. trained A)-A stated R84 does not elchair, and staff push him in the dining room. On 3/3/16, at 2:42 p.m. On 3/3/16, at 2:42 p.m.	F3	112	completed x 4 weeks. All audit rest be reviewed at QAPI for tracking a trending. QAPI team will then adjuschedule accordingly to trending identified.	nd	
	ambulated that she ambulation progran was documented or	was aware of, and if an news, was ordered and provided, it is the computer program. It is find any order for R84 to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245186	B. WING			C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	, 33	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Corporate registere recommendations f the care plan, into control of the care plan.	on 3/3/16, at 4:27 p.m. ad nurse (RNC)-A stated rom therapy are transferred to care tracker, and onto the	F3	12		
	staff were provided ambulation progran	are sheets. RNC-A stated education on providing the n, and the registered nurse hly the effectiveness of the as needed.				
	PT-A assisted R84 wheeled walker and wheeled walker was time, as no walker was pt-A stated R84 ar and no change was since he was discharged she was not	ion on 3/3/16, at 4:55 p.m. to ambulate, with the use of a d transfer belt. PT-A stated a s provided from therapy at this was available in R84's room. Inbulated with a shuffled gate, a noted to R84's ambulation arged from therapy. PT-A aware R84 was not provided ince as recommended.				
F 315 SS=D	requested, but not p	HETER, PREVENT UTI,	F 3	15		4/12/16
	assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder ec.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245186	B. WING			03/0) 03/ 2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	33/2010
GOLDEN	I VALLEY REHABILITA	ATION AND CARE CENTER			505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
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F 315	Continued From pa	ge 24	F 3	15			
	by: Based on observate review, the facility facatheter was inserted according to the phyresidents, (R5), revicatheter. Findings include: R5's quarterly Minimal 1/6/16, indicated hereofor activities of daily bathing, eating, and indwelling Foley cate neuromuscular dystem of the findicated the reside (suprapubic) cathet as needed if pulled 22 or 24 FR (french liquid unit of measure included neurogenic (urinary tract infection R5's care plan, most indicated the resider related to neurogen and recurrent UTI's resident was to have catheter, and staff versider the resider of the resident was to have catheter, and staff versident was installed to the resider of the resident was to have catheter, and staff versident was installed to the resider of the resident was to have catheter, and staff versident was installed to the resident was to have catheter, and staff versident was installed to the resident was to have catheter, and staff versident was installed to the resident was to have catheter, and staff versident was to have catheter.	ers dated February 2016, nt was to have his S/P er changed every month, and or plugged, and was to use a)/5 cc's(cubic centimeters) (a rement). R5's diagnosis			1.R5 suprapubic catheter plan of common was reviewed and updated as appropriate. 2.All residents with urinary catheter been reviewed and plan of care upons appropriate. 3.Nursing staff will be educated on procedure for working with suprapucatheters. 4.DON or Designee will complete roudits regarding catheter reinsertion techniques monthly for 3 months. A results will be reviewed at QAPI for tracking and trending. QAPI team then adjust audit schedule according the trending identified.	rs have dated proper ubic andom n Audit	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			C 03/2016	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 03/1	03/2010	
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F 315	10:22 a.m. R5's supplace, and Register would need to be reprepare to insert the observed RN-B had of a S/P catheter. If wrong equipment, a RN-B proceeded to placed on non-steril assistant (NA)-A's a non-sterile gloves, a the end of the S/P cathe with insertion, the s regarding sterile techad been using. R she was going to us 22 or 24 FR as dire left R5's room to se to obtain the correct licensed practical n supplies, including a sterile gloves, and t under sterile technic	of cares for R5 on 3/3/16, at prapubic catheter was not in ed nurse (RN)-B indicated it eplaced. RN-B proceeded to eplaced. RN-B indicated she had the end obtained a S/P catheter. obtain a 26 FR S/P catheter, elegioves, requested nursing essistance and had her applyed and applied sterile lubricant to eatheter and was prepared to enter. Before RN-B continued eurveyor questioned RN-B chnique and the supplies she enter and the S/P catheter see was a 26 FR, and not the coted by the physician. NA-A ek additional assistance and the supplies. At 10:31 a.m., eurse (LPN)-D arrived with a 22 FR S/P catheter was inserted	F3	15			
F 329 SS=D	UNNECESSARY D Each resident's dru unnecessary drugs drug when used in	GIMEN IS FREE FROM	F 3:	29		4/12/16	
	without adequate m	ionitoring; or without adequate se; or in the presence of					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING (X3) DATE S		E SURVEY IPLETED			
		245186	B. WING			C 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 329	should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessary as diagnosed and record; and reside drugs receive grade behavioral interversident.	nces which indicate the dose or discontinued; or any	F 3	29		
	by: Based on interview facility failed to ensures were meanti-hypertensive results (R84) and effective pain medication was parameters for 1 of for unneccessary results for the facility of th	w and document review, the sure orthostatic blood onitored for administered medication for 1 of 5 residents eness of as needed narcotic as evaluated using adequate of 5 residents (R66) reviewed medication use. OS dated 1/7/16, identified g heart failure, hypertension are), and dementia. The MDS severe cognitive impairment, assistance with transfers, and hout human assistance.		1.R84 treatment record has be reviewed and updated to reflect orthostatic blood pressure more MD has been updated on result and reviewed resident plan of accordingly. R66 physician or pain medication has been clarify physician and updated to reflect accordingly. 2.All residents on hypertensive medications were reviewed and updated as necessary for appropriate monitoring. All residents on namedication were reviewed and clarified for clear parameters a necessary. 3.Nurses will be educated regarders.	et necessary nitoring. The lts obtained care ders for fied by the et changes d MARS opriate arcotic pain orders	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/0	; 3/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	33.5	J/2010
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F 329	identified orders for (medication to treat milligrams (mg) twi carvedilol (medicat pressure) 25 mg poinitiated on 5/2/15. to check orthostatic and vital signs to be Review of R84's mr. (MAR) for March 20 monitor for side effincluded dizziness, orthostatic hypoten Review of R84's tr. (TAR) identified an orthostatic blood pridentified the follow orthostatic blood pridentified and 2/28/14/16 and 2/28/15 blood pressure checorthostatic blood pridentification pridentified the follow orthostatic blood pridentified the follow orthostati	cian orders dated 2/3/16, amlodipine besylate thigh blood pressure) 5 ce daily by mouth (po), and ion to treat high blood twice daily which had been The physician orders directed blood pressure once a week exchecked weekly. edication administration record 0.16, identified staff were to ects of medications which fatigue, hypertension, and sion. eatment administration record order dated 5/2/15, to monitor ressures weekly on Friday, ing for completion of the ressure: of 4 opportunities	F 329	documentation requirements for dimonitoring to evaluate effectivene medications, potential side effects unnecessary medications. 4. Pharmacist or Designee will commonthly random audits to ensure adequate drug monitoring and documentation is being completed or designee will complete random audits for 4 weeks to ensure documentation of side effect moniand PRN Analgesic Record/ Pain Sheet is being completed Audit rewill be reviewed at QAPI for trackit trending. QAPI team will then adjuschedule accordingly to the trendicidentified.	ss of , or nplete d. DON weekly toring Flow esults ng and ist audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245186	B. WING _		03/0	3/2016
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F 329	orthostatic blood pr completed for R84	d nurse (RNC)-A stated essures had not been as ordered, and it was her orthostatic blood pressures	F 32	29		
	LACK OF MONITO	RING FOR NARCOTICS:				
	2/18/16, identified F	num Data Set (MDS) dated R66 had intact cognition, of pain, and received needed (PRN) pain				
	identified orders for > "Fentanyl C2 [cor [micrograms per ho change every 72 ho > "Fentanyl C2 100 change every 72 ho > "Methadone HCL tabs [tablets] [30 m and > "Oxycodone [a na Tablet 1-2 tabs[ta every bedtime as no Review of R66's Me	mcg/hr Apply 1 patch and ours," and C2 10 mg [milligrams] 3 g] by mouth every bedtime," arcotic pain medication] 5 mg ablets] [5-10mg] by mouth				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		. (X	(X3) DATE SURVEY COMPLETED			
		245186	B. WING		_	C 03/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STA 7505 COUNTRY CLUB DRIV GOLDEN VALLEY, MN 5	/E	03/03/2010
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F 329	-MAR dated 1/2016 doses of the as-needuring the month. I documentation to dordered 5 mg dose needed narcotic me PRN (as-needed) A Sheet (tool used to effectiveness of adri/1/16 to 1/31/16, id date and time of ad and numerical ratin and follow-up to the However, all of thes R66's records. -MAR dated 2/2016 doses of the as-needuring if [1-2 tablets] four hours] PRN" and doses of the as-needure was transcribed whiming i-ii [1-2 tablets] four hours] PRN" and doses of the as-needure if R66 reference or 10 mg dose of the medication. PRN (all provided medications, pain rating, the medication if leds were left blank R66's progress not 2/28/16, were reviewed identifying what doses it was transcribed medications. R66's progress not 2/28/16, were reviewed identifying what doses it was transcribed which is the provided medication in the provided medication is progress not 2/28/16, were reviewed identifying what doses it was transcribed which is the provided medication in the provided medication is progress not 2/28/16, were reviewed identifying what doses it was transcribed which is the provided medication in the provided medication is provided medication.	identified R66 received 20 eded narcotic pain medication However, there was no etermine if R66 received the or 10 mg dose of the as edication. R66's analgesic Record / Pain Flow monitor pain and medication ministered medication) dated dentified spacing to record the ministration, pain description g, the medication provided, e provided medication. Se fields were left blank on the fields were le	F3	329		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			C / 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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F 329	when interviewed registered nurse (F complaints of pain [medications] to he scheduled narcotic narcotic medication two tablets of as-ne RN-E stated she us many tablets of the medication to provinursing staff should provided and it's ef Analgesic Record of medication was ad was not aware of a would be document interventions, mon as-needed narcotic Analgesic Record, reviewed the Januar records and stated effectiveness comparcotic medication written here," and suse it each time." unable to determin needed narcotic medication time R66 received. During interview or assistant director of were expected to us to document a resi effectiveness monisupposed to use the	follow up on if the provided	F 32	9		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		(X3) DATE SURVEY COMPLETED		
		245186	B. WING		C 03/03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	33/33/2313
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 329	anymore, "I thought ago," and staff should have a staff should hav	s (i.e. one to two tabs) t that was banned a long time ald have clarified the order. orders for as needed narcotic dity failed to ensure staff histered dose, and then nistered medication to ensure necessary in managing R66's agement policy dated 7/2015, an administered scheduled	F 329		
F 332 SS=D	resident pain intense effectiveness of intente the [MAR]." A facility Medication 7/2015, directed standard administration and medication in the number of the back of the [MA 483.25(m)(1) FREE RATES OF 5% OR	OF MEDICATION ERROR	F 332		4/12/16
	by: Based on observate review, the facility factorial were administered accordance with ph	NT is not met as evidenced cion, interview and document ailed to ensure all medications in a timely fashion in sysician orders and facility esidents (R101) observed to		1.R101 is no longer a resident at th facility. The facility will provide medications in a safe, professional manner to include right drug, right re right dose and preparation, right pat	eason,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			03/0) 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 332	resulted in a medi (percent). Findings include: During an observa administration on practical nurse (LI administer R101's administered Bac Sulfate ER 15 mg tablet with various that time. LPN-H s R101's Morphine a.m., and Baclofe scheduled for 8:00 an appointment to between 8:30 and been busy this more R101's admission diagnoses of paradisorder, and chrow Minimum Data Seidentified R101 has almost constantly pain at night, and due to pain. During an intervie R101 stated he has abdomen, back, his pasms in his legal medications, especified given late or them. R101 indicated Sulfate and Baclo	ation of medication 3/2/16, at 9:28 a.m., licensed PN)-D was observed to medications. LPN-E ofen 20 mg tablet, Morphine tablet and Lorazepam 2 mg other medications to R101 at stated she was aware that Sulfate was scheduled for 7:00 m and Lorazepam were 0 a.m She indicated R101 had day and wanted to be up 9:00 a.m., but stated, "It's just	F3	332	right time, right route and right documentation with oversight to en medication delivery system that me professional standards. Medicatio Administration Records have been audited to ensure residents are recomedications in a safe professional manner. 2. All nurses will receive education regarding the policy of medication administration and seeking out assif having difficulty completing medical administration timely. 3. DON or Designee will complete reveekly medication administration. All aud be reviewed at QAPI meeting for trand trending. QAPI team will then a audit schedule accordingly to the tridentified.	eets n ceiving sistance cation random audits f its will racking adjust	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245186	B. WING				C 03/2016
NAME OF F	PROVIDER OR SUPPLIER	240100			STREET ADDRESS, CITY, STATE, ZIP CODE	03/0	03/2010
COLDEN	IVALLEV DEHABILIT	ATION AND CARE CENTER			505 COUNTRY CLUB DRIVE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE CENTER		(GOLDEN VALLEY, MN 55427		
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F 332		ge 33 ted it was difficult to manage	F 3	32			
		s that his medications were					
	"Morphine Sulfate [in ER [extended releat tablet1 tab by more backlofen [medication spasms, pain and smouth four times das "Lorazepam [medication substitution	rders, dated 2/3/16, included, medication used to treat pain] se] 15 mg [milligrams] uth every 8 hours," for pain, on used to treat muscle tiffness] 20 mg tablet, 1 tab by aily," for muscle spasms, and, ation used to treat anxiety] 2 mouth three times daily," for					
	dated 3/16, indicate administered at 7:00 p.m., Baclofen was a.m., 12:00 p.m., 4:	administration record (MAR), ed Morphine Sulfate was to be 0 a.m., 3:00 p.m., and 11:00 to be administered at 8:00 00 p.m., and 2:00 a.m., and be administered at 8:00 a.m., 0 p.m.					
	stated, when giving have an hour before scheduled time] to g medications were g	on 3/3/16, at 1:06 p.m., RN-H scheduled medications, "We e and an hour after [the give them," and indicated if iven outside of that time a considered a medication					
F 353	Administration, date licensed nurse and/ check the following Right medication, R Right route, Right re	y's procedure, Medication ed 7/15, included, "The for medication assistant will to administer medication: light dose, Right dosage form, esident, and Right time." ENT 24-HR NURSING STAFF	F 3	53			4/12/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245186	B. WING _			C 03/2016	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 353 SS=E	PER CARE PLANS The facility must ha provide nursing and maintain the highes and psychosocial widetermined by reside individual plans of ormal part of the facility must provide numbers of each of personnel on a 24-care to all residents care plans: Except when waive section, licensed numbers on the facility nurse to serve as a duty. This REQUIREMED by: Based on observative review, the facility for the facility of the facilit	ave sufficient nursing staff to d related services to attain or st practicable physical, mental, well-being of each resident, as dent assessments and	F 35	1.Facility has reviewed staffing ensure facility has sufficient staf to meet resident needs. This is through daily evaluation of resid census and acuity levels by the designee. Also Refer to F282, F312, F314, F332, F364 plan of	fing levels done ent DON or		
	FM-F), and 7 of 7 : RD-A, NA-F, LPN-A	2 of 3 family members (FM-E, staff members (NA-H, CDM-A, A, SM-A, SM-B) who identified ack of adequate staff in the		correction. 2.Residents in the facility will red by skilled/experienced staff that supervised to ensure care need being met. Administrator/DON of	are s are		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		03/03/	/2016	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 33/33/	, = 0.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIUE DEFICIENCY)	D BE C	(X5) COMPLETION DATE	
F 353	MET: See F311 as the fa assistance with eat residents (R90) revilving (ADLs). See F364 as the fa served hot and pala (R66) who complain the state of the served he did not fe available in the facing the served he did not fe available in the facing the served he did not fe available in the facing the served he se	cility failed to ensure timely ing was provided for 1 of 3 iewed for activities of daily cility failed to ensure food was atable for 1 of 2 residents ned about cold food. ERNS WITH LACK OF FING: imum Data Set (MDS) dated R39 had intact cognition and assistance with his activities of 2/29/15, at 5:22 p.m. R39 el there was enough staff lity to help residents, "I think iff." R39 stated he will request aff will tell him they have other they can help him, and it, "Will e received help, "They will	F 353	designee will review scheduled stadaily to ensure adequate staffing I and to ensure appropriate quantity quality, and composition of staff. 3.Staff will receive education rega sufficient staffing levels and provionursing and nursing related service accordingly. 4.Executive Director will complete weekly audits x 4 weeks to ensure adequate staffing levels are provionclude interviews with staff. Carin Partners will complete weekly audits regarding customer service and resatisfaction with cares. Audits will reviewed at QAPI meeting and QAWill adjust audit schedule appropribased on findings.	evels //, rding ding es random eded to g iits esident be API team		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING				03/ 2016
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	TATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	had intact cognition assistance with her During interview or stated she did not for staff to ensure she manner. R68 required cares, and at times one staff member of doesn't get her income a result. R68 report do not have time to sometimes it takes call light answered. R66's annual MDS had intact cognition assistance to compuring interview or stated there was not residents at the fact staff[ed]." R66 staff medication late from was concerning to hazard." R66 indict answered timely, so to two hours" for so her, "The care is so R110's quarterly MIR110 had intact cognition interview or stated he did not the facility to help red. Staff often to staff of the staff	ents. 2S dated 2/9/16, identified R68 in and required extensive (ADLs). 2/29/16, at 6:52 p.m. R68 feel the facility had adequate received care in a timely ired two staff to assist her with a during the night, there is only working so she had to wait and ontinence product changed as rted staff always tell her they help her when asked, and up to 45 minutes to get her dated 2/18/16, identified R66 in and required extensive blete her ADLs. 2/29/16, at 6:58 p.m. R66 on the enough staff to help cility, "They are so short the she frequently received her in the nursing staff and this her, "Its become a real ated call lights were not cometimes having to wait, "Up promeone to answer it and assist to bad."	F3	353			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00/1	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	having to sit in stoo having a bowel movuncomfortable. R127's quarterly MIR127 had intact cog During interview on stated there was not R127 stated he offer to receive his medicupsets him. R88's annual MDS had intact cognition assistance to comp During interview on stated she did not for the facility because with toileting or incompassion as she needed. R8 scheduled bathing of consistent basis who activities. R137's quarterly MIR137 had intact cognoring interview on stated she did not for the facility to help he hours were they need. Hours were the worsignificant pain and so she called anoth in the building to har "It's like no one up is stated it had taken,"	I waiting to get help after vement which made him feel DS dated 1/6/16, identified gnition. 3/1/16, at 9:59 a.m. R127 at enough staff at the facility. In has to wait for long periods cations and meals, and it dated 1/15/16, identified R88 and required extensive lete her ADLs. 3/1/16, at 10:19 a.m. R88 eel there was enough staff at she was not being assisted ontinence care every two hours 8 stated she didn't receive her or morning cares on a ich often made her late to	F3	353			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED		
		245186	B. WING _			C / 03/2016		
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
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F 353	R77's quarterly MD R77 had intact cog assistance to comp During interview or stated he did not fe help deliver meals in the facility becau pain medications la FAMILY CONCER! ADEQUATE STAF When interviewed member (FM)-E state most of his wife's of enough staff to help During interview or stated there was no FM-F had noticed of getting assistance there was more he STAFF CONCERN COMPLETE CARE STAFFING: During interview or assistant (NA)-H st don't have "quite et assigned cares cor meal times. NA-H hardest, and the st	ols dated 12/2/15, identified nition and required extensive plete his ADLs. ols 3/1/16, at 11:31 a.m. R77 elel there was enough staff to or medications to the residents use he receives his food and ate often times. NS WITH LACK OF FING: on 3/1/16, at 11:21 a.m. family ated he did not feel there was facility to make sure residents hey needed adding his wife medications late as a result. The defended here is not possible to the possible of the facility. The concerns with residents not to eat at meal times, "I wish	F 3	53				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245186	B. WING _		03	C / 03 / 2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00	703/2010
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F 353	On 3/2/16, at 8:59 a manager (CDM)-A were interviewed. On ursing staff to help was an "ongoing pr dietary departments food. RD-A stated the assist with meal time department and the When interviewed assistance to eat be staff to help everyoneed more help." In reported the concenursing and a floor During interview on practical nurse (LP) needed to be more for the residents. So required, "total care staffing did not allow complete it, "[It would not help to make the facility necare was being conforders from the phytimely, and treatme completed at all be the staff to do them neglected, and the getting worse lately (DON) changing see	a.m. the certified dietary and registered dietician (RD)-A CDM-A stated the lack of pass meals and room trays oblem" which affected the sability to serve palatable he lack of nursing staff to nes was, "affecting my e residents point blank." on 3/2/16, at 9:23 a.m. NA-F nts often have to wait for ecause there is not enough ne eat at the same time, "we NA-F stated he/she had rns to the assistant director of	F 35	53		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		05	C 3/ 03/2016	
NAME OF PROVIDER		ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	ZIP CODE	703/2010	
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their as lack of the factor on 3/3 members was, "It help up because the lactor behavior stated out, "we voiced perceive the factor the research of the resider	staff was so ility should conditive should conditive should conditive should conditive should be set they have a some state is concerns to be set the nurses a shen State is concerns to be set the nurses a shen State is concerns to be set they should be set to set they should be should	s. Further, SM-B stated the detrimental to the residents, lose down. n anonymous interview, staff ated the staffing at the facility /'s" and, "we [staff] need more A stated residents get upset to wait for cares, and added atributes to increased the residents get upset. SM-A nd social workers only help here" and when the staff administration it was laining. Further, SM-A stated more staff so they, "could give	F3	53			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245186	B. WING _			C 0 3/2016
	PROVIDER OR SUPPLIER I VALLEY REHABILIT.	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 353 F 364 SS=D	A facility policy and requested, but none 483.35(d)(1)-(2) NU PALATABLE/PREF Each resident recei food prepared by m	procedure on staff was e was provided. JTRITIVE VALUE/APPEAR, ER TEMP ves and the facility provides lethods that conserve nutritive ppearance; and food that is	F 35			4/12/16
	by: Based on observat review, the facility for served hot and pala (R66) who complain Findings include: R66's annual Minim 2/18/16, identified F was independent w During interview on stated she received because she didn't in the dining room, "Generally always of During observation 3/2/16, at 7:00 a.m. toast, sausage links kitchen. CK-A check using the facility the french toast was 14	NT is not met as evidenced ion, interview, and document ailed to ensure food was atable for 1 of 2 residents ned about cold food. The Data Set (MDS) dated af 666 had intact cognition, and ith eating after set up by staff. 2/29/16, at 6:49 p.m. R66 meal trays in her room like eating with other residents and stated her food was, cold when served to her. of the breakfast meal on cook (CK)-A prepared french is, and oatmeal in the facility exed the food temperatures ermometer and identified the codegrees (Fahrenheit, F), the 170 degrees, and the oatmeal		1. R66 is receiving palatable meals proper temperature. 2. All residents will receive palatable meals at the proper temperature. 3. Cooks were re-educated on taking temperatures and reheating when not at the proper temperature prior leaving the kitchen. Nursing staff his been re-educated on the dining profor resident who receive trays. 4. Dietary Manager or designee will conduct random weekly food temperature to meal service. It that food is not at the proper temperature to ensure that it is serviced will be reheated to the proper temperature to ensure that it is serviced and palatable. In addition, Dietary Manager or designee will conduct reweekly test trays to ensure that food served hot and palatable x 4 weeks Results of audits will be reviewed a for tracking and trending and QAPI will then adjust audit schedule accordingly.	ng food is to food ave ocess I ing in f found erature, ved hot random d is s. at QAPI	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 364	serving pans, and phought to the fourt stated room trays with meal services, and (CDM)-A stated two were served their troom was served to food. At 7:22 a.m. was brought up to ta.m. dietary aide (Dimeals to the reside A mobile cart was pwith trays and silved delivery, however, right delivery, how	The food was placed in metal placed in a steam table being in floor dining room. CK-A were served throughout the certified dietary manager or residents, including R66, ays first before the dining in help maintain the heat of the the steam table with the food the fourth floor, and at 7:34 (A)-A began to serve breakfast ints seated in the dining room. Placed next to the steam table of the tware set-up for room tray no food was put on to plates or ents in their rooms. At 7:49 the residents in the dining room eir breakfast meal, and no in delivered. CDM-A was meal service and left the eventh eroom tray orders. At the easter the steam table for), CDM-A started to prepare ents, including R66. The in a sample tray, and nursing look R66's covered meal tray, the time the sample tray was in her room. DA-A temped the sample tray, and stated the grees (F), the french toast was a sausage was 95 degrees, tray felt cold to the touch. At long the property of the sample tray was on her room was ended to the touch. At long the property of the sample tray in the french toast was great along with the ray, and R66 stated her french and her food was cold. NA-H and observed R66's room the french toast was, "Ice cold" of grab another tray" for R66.	F3	364			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7505	EET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427	1 00/	33/2010
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F 364	stated the nursing sethe room trays, and should be served fir remains warm. NA busy today" and un however, adding it, stated he was unsurwhen he served it to kitchen['s] responsional During interview on and registered dieti have been served a "To help hold temps complaints from he cold. The nursing sethe meals to reside "Didn't happen" as should have been semeal service. Furth "On-going problem and their support was a facility Room Seridentified the facility residents a pleasur offering nutritious, a resident room where directed staff to ser not identify when reduring the meal served fire the facility residents appears to serve the meal served staff to ser not identify when reduring the meal served fire the facility residents appears to serve the fire the facility resident room where directed staff to ser not identify when reduring the meal served fire the facility resident room where the facility resident room room room room room room room roo	on 3/2/16, at 8:27 a.m. NA-G staff were responsible to serve at two residents, including R66, rest to make sure their food -G stated the staff were, "Very able to serve them first "Happens sometimes." NA-G re how hot R66's food was a her because, "That is the bility." 3/2/16, at 8:59 a.m. CDM-A cian (RD)-A stated R66 should at the beginning of the meal, eratures," because of past rabout food being served staff was responsible to serve ents in their rooms, but that, it was supposed to, and R66 served at the beginning of the ner, CDM-A stated this was an, ', and the lack of nursing staff as affecting the meal service. Vice policy dated 7/2015, y, "Strives to provide all able dining experience by attractive meals served in the n required." The policy we room trays covered, but did nom trays were to be served vice to maintain heat and	F3	64			
F 371 SS=E	483.35(i) FOOD PF	serving the prepared food.	F3	71			4/12/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00/1		
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F 371	considered satisfac authorities; and (2) Store, prepare, under sanitary cond	om sources approved or ctory by Federal, State or local distribute and serve food ditions	F 37	1			
	by: Based on observareview, the facility for based product was to reduce the risk of potential to affect 1 the facility as who consumed the food. Findings include: An initial tour of the on 2/29/16, at 12:5 manager (CDM)-A (RD)-A. During the underneath a metastated was a, "Nou prepare foods for rehours. A one gallo brown colored food labeled, "Tuna Sala"02-23-16" (six day container was approvith saran wrappin the cooler, includin available for reside	tion, interview, and document failed to ensure left-over fish discarded in a timely manner of food borne illness. This had 5 of 15 residents identified by could have potentially d. It facility kitchen was completed 5 p.m. with certified dietary and registered dietician etour, a cooler was reviewed allic serving table which RD-A rishment area" used to esidents in between meal in plastic container of light awas in the cooler which was ad," with a date written, is prior) in black marker. The foximately 1/2 full and covered g. RD-A stated the foods in g the tuna salad, were int consumption and the tuna been removed after, "Three		1.Left-over fish product was immediscarded and coolers were inspect determine there were no other foo products that needed to be discard 2.Facility staff were re-educated of for discarding leftover refrigerated 3.Dietary Manager or designee will conduct weekly audits of coolers for proper discarding of leftover items weeks. Audits will be reviewed at 0 meeting and QAPI team will adjussishedule appropriately based on fill	cted to d ded. n policy items. I or x 4 QAPI t audit		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 00/	05/2010
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F 371	culinary manager (0 tuna salad had bee "Whoever wanted it any residents had restated the facility portion of after three day in the cooler was ar stated the left-over food" and could caulit was consumed af Further, CDM-A stathe one gallon contato make, "About 15 stated it should have days. A facility Refrigerate 7/2015, identified allabeled with the iter then "Discard refrigung 483.55(b) ROUTINI SERVICES IN NFS The nursing facility an outside resource §483.75(h) of this provered under the Sential services to making appointment transportation to an	o.m. CDM-A, RD-A and CM)-A were interviewed. The n made on 2/23/16 for, "and would have been used if equested tuna salad. CDM-A olicy was to discard left-over as, and leaving the tuna salad in oversight by the cook. RD-A tuna salad was a, "Higher risk ase potential food poisoning if ter three days of being made, ted the amount remaining in ainer was enough tuna salad [sandwiches]", and again the been discarded after three or Storage policy dated after three	F 3			4/12/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		TIPLE CONSTRUCTION (X3) DATE S COMPL		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	This REQUIREMENT by: Based on interview facility failed to coor services for 1 of 3 r dental hygiene and Findings include: R110's quarterly Mi 1/7/16, identified the intact, required externation activities of daily living grooming, bathing, independent with eaundated nursing as staff to provide assistant of provide assistant of the provide assistance with action of the provide assistance as a seen the dentist.	and document review, the rdinate dental care and esidents (R110) reviewed for care. Inimum Data Set (MDS) dated the resident was cognitively ensive assistance to complete right (ADL's) including dressing, and toileting, and was rating once he was set up. An sistant worklist directs the st with activities of daily living. 3/1/16, at 8:55 a.m. R110 rems with cavities and his, dup." R110 stated he had dentist, however, he has not on 3/1/16 at 8:46 a.m., NA-B some times does not want to ring a subsequent interview on ., NA-B stated (R110) required vities of daily living but does	F 4	12	1.R110 was evaluated by nursing a scheduled for non-emergency dent on 4/7/16. 2.All residents have been reviewed potential dental needs, and referral been completed as indicated. 3.All staff will received education regarding the policy for routine and emergency dental services. 4.Social Services will continue to ordental services with admissions, arreview on a quarterly basis for rout services. Caring Partners will conditive weekly audits with residents regard dental service requests. Results of audits will be reviewed at QAPI for tracking and trending.	for ls have	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	03/0	03/2016
GOLDEN	VALLEY REHABILII	ATION AND CARE CENTER		G	OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	be seendental." During interview on health unit coordina not seen the dentist in January 2016. Sh	ge 47 cated R110 was "put on list to 3/3/16, at 10:12 a.m. with tor (HUC)-A stated R110 had t even though he was referred ne stated he was last seen by 4, over 1/1/2 years ago.	F 4	.12			
F 425 SS=B	During interview on stated that she had R110 during care or an appointment in fischedules were rev with SS-B and HUC not been on schedule stated that social se schedule ancillary sconference and as	3/3/16 at 4:49 p.m., SS-B reviewed dental status with onference and had scheduled ollow up. Resident dental iewed for 2/16, 3/16, and 4/16 and alle for a dental exam. SS-B ervices was responsible to ervices during care needed, but this was missed.	F 4	125			4/12/16
	drugs and biologica them under an agre §483.75(h) of this p	art. The facility may permit el to administer drugs if State y under the general					
	(including procedure acquiring, receiving	drugs and biologicals) to meet					
		nploy or obtain the services of ist who provides consultation					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245186	B. WING			C / 03/2016
	PROVIDER OR SUPPLIEF	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		30,2310
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	This REQUIREME by: Based on observareview, the facility solution available not expired. This residents or staff vexpired solution. Findings include: On 3/3/16, at 12:1 storage room was practical nurse (LF room contained ar Purified Protein Detest for exposure to date written on the "1-13-16." LPN-B was available for restated the remaining approximately fou it should have been being opened on "1.13".	ne provision of pharmacy	F 4	,	ons have ly within sage. following blete random er medication f audits will for tracking then adjust	
	refrigerator for exp however, she was specific system to were identified. During interview o registered nurse of	pired medications and solutions, unaware if the facility had a ensure expired medications on 3/3/16, at 3:44 p.m. onsultant (RNC)-A stated the should have been discarded				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245186	B. WING		C 03/03/2016
NAME OF F	PROVIDER OR SUPPLIER	210100		STREET ADDRESS, CITY, STATE, ZIP CODE	03/03/2016
GOLDEN	VALLEY REHABILITA	ATION AND CARE CENTER		7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 425	Medication effectives A facility undated In flowsheet identifying Recommendations, should be, "Date[edunused portion after the control of the	for thirty days because the eness could be decreased.	F 42	25	
F 428 SS=D	on several occasion unable to be reache 483.60(c) DRUG RI IRREGULAR, ACT	ns during the survey, but was ed for interview. EGIMEN REVIEW, REPORT	F 42	28	4/12/16
	the attending physic	st report any irregularities to sian, and the director of reports must be acted upon.			
	by: Based on interview facility failed to ensuidentified irregulariti			1.R66 drug regime has been revier and updated as indicated. 2.All residents with PRN pain medic have been reviewed to identify pote irregularities with dosing and monit for effectiveness. 3.Nurses have received education regarding documentation requiremental properties.	cations ential oring

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	G		PLETED
		245186	B. WING			03/ 2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	R66's annual Minin 2/18/16, identified of frequent episodes scheduled and as imedications. R66's signed physicidentified orders fo prentanyl C2 [confinition of continuous per	num Data Set (MDS) dated R66 had intact cognition, of pain, and received needed (PRN) pain cian orders dated 2/3/16, r the following narcotics: ntrolled drug] 25 mcg/hr our] Apply 1 patch and ours," and neg/hr Apply 1 patch and ours," and C2 10 mg [milligrams] 3 mg] by mouth every bedtime," arcotic pain medication] 5 mg ablets] [5-10mg] by mouth every bedtime in a color and 2/16 identified the color and color	F 428	monitoring for potential dosing irregularities. Pharmacy Consu included in education relating to lack of effectiveness and dosin narcotics. 4.DON or designee will comple weekly audits for documentatio clarification of potential irregula dosing and monitoring for effect prn pain meds x 4 weeks. Resu audits will be reviewed at QAPI for tracking and trending. QAPI then adjust audit schedule acceptable trending identified.	o noting g of te random n and rities with tiveness of ults of meeting team will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		245186	B. WING _			C / 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	.	30,2313
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	doses of the as-new before the order was transcribed whom gi-ii [1-2 tablets] four hours] PRN" a doses of the as-new However, there was determine if R66 reword 10 mg dose of the medication. PRN (Pain Flow Sheet of identified spacing the administration, pain rating, the medication the provided medication had been provided the medication of pain [medications] to he scheduled narcotic marcotic medication two tablets of as-new RN-E stated she us many tablets of the medication to provinursing staff should	6, identified R66 received 19 eded narcotic medication, as discontinued. A new order nich identified, "Oxycodone 5 PO [by mouth] Q 4 HRS [every nd R66 received 14 additional eded narcotic medication. In the second of the ordered 5 mg dose as needed narcotic as-needed) Analgesic Record dated 2/1/16 to 2/29/16, to record the date and time of the description and numerical from provided, and follow-up to eation. However, all of these as needed 1/1/2016 through the wed but lacked documentation are of the as needed en administered, why R66 had as needed narcotic follow up on if the provided	F 42	28		

			CON	TE SURVEY MPLETED		
		245186	B. WING _			C / 03 / 2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		30,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	Analgesic Record medication was ad was not aware of a would be documer interventions, mon as-needed narcotic Analgesic Record, reviewed the Januarecords and stated effectiveness comparcotic medication written here," and suse it each time." unable to determin needed narcotic mime R66 received During interview or assistant director of were expected to be to document a resi effectiveness monisupposed to use the stated she did not writing range order anymore, "I though ago," and staff shood on 7/16/15, no irregular 10/14/15, no irregular 11/14/15,	each time a as-needed pain ministered. RN-E stated she any other location the staff ating their non-pharmacological itoring or follow-up of the comedication than on the PRN "not that I'm aware of." RN-E ary and February analgesic there was no monitoring of the pleted for R66's as needed in use, "It should have been staff, "Need to be re-taught to Further, RN-E stated she was en how many tablets of the as edication had been given each the as needed narcotic. In 3/3/16, at 12:56 p.m. the of nursing (ADON) stated staff use the PRN analgesic records dent's pain, and the storing for it, "[They're] hat sheet." Further, RN-B think physicians should be so (i.e. one to two tabs) at that was banned a long time and have clarified the order. In a sylvential control of the control of th	F 42	28		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	` ´COM	E SURVEY PLETED
		245186	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	00/	55/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	medication, the faci identified the admin monitored the admin monitored the admin it was effective and pain and the consul identify this irregula. The consulting phar several occasions of unable to be reached. A facility policy relate pharmacist was requipolicy titled Consult. Pharmacist consults "Medication Regime in the Med Administ this portion was not 483.60(b), (d), (e) Discontinuous pharmacist consults alicensed pharmacist consults this portion was not 483.60(b), (d), (e) Discontinuous precords of receip controlled drugs in accurate reconciliate records are in order controlled drugs is reconciled. Drugs and biological labeled in accordan professional princip appropriate accessed.	orders for as needed narcotic lity failed to ensure staff istered dose, and then nistered medication to ensure necessary in managing R66's ting pharmacist failed to rity. Transcist was contacted on during the survey, but was ad for interview. The facility provided ants, which indicated "for ant recommendations, refer to be Review" procedure located tration Program. However, provided as requested. The RECORDS, UGS & BIOLOGICALS The ploy or obtain the services of sist who establishes a system than disposition of all sufficient detail to enable and ion; and determines that drugh and that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the	F4				4/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		PLETED				
		245186	B. WING			C 03/2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	facility must store locked compartme controls, and perm have access to the The facility must permanently affixe controlled drugs li Comprehensive D Control Act of 197 abuse, except whe package drug dist	h State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to e keys. Provide separately locked, ed compartments for storage of sted in Schedule II of the grug Abuse Prevention and 6 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose can	F 4	31		
	by: Based on intervier facility failed to en (transdermal narch according to facility reduce the risk of (R66) reviewed for This had potential R147, R65, R111) current orders for Findings include: A facility provided Patche(s) listing in	ew and document review, the sure Fentanyl Patches otic patches) were destroyed by policies and procedures to diversion for 1 of 5 residents runnecessary medication use. to affect 4 of 4 residents (R66, residing in the facility who had Fentanyl patches. undated titled Fentanyl dentified R66, R147, R65, and orders for Fentanyl (a narcotic dermal patches.		1.R66 medication administrated has been reviewed and updated documentation and adherence transdermal narcotic patches 2.All residents receiving transmarcotic patches medication administration record has been and updated. 3.Nurses have received educt following policy for transderm patch destruction. 4.DON or designee will compoweekly audits for 4 weeks to appropriate transdermal narcodestruction. Results of audits reviewed at QAPI for tracking trending. QAPI team will then	ted to include te to destruction. dermal en reviewed eation on al narcotic elete random ensure otic patch will be J and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		E SURVEY PLETED					
		245186	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	identified R66 had of C2 [controlled subs an hour] Patch A every 72 hours," an Patch Apply 1 pa hours." Further, R identified nursing st patch down toilet for must witness." R66's medication a dated 2/2016, ident administering nurse Fentanyl patch by w space to record who disposed of the old [initials]", and "NUR staff to have two nudestruction as direct R66's MAR identified changes occurred, times indicated two indicate the disposation with the destruction, "mark you saw it." Fentanyl patch destruction, "mark you saw it." Fentanyl patch destruction, "mark you saw it." Fentanyl patch destruction to end correctly, and to medication isn't bei removed patches sentanyl patch es sentanyl patch sentanyl patch to end to medication isn't bei removed patches sentanyl patch es sentanyl patch	cian orders dated 2/5/16, current orders for, "Fentanyl tance] 25 mcg/hr [micrograms pply 1 patch and change d, "Fentanyl C2 100 mcg/hr tch and change every 72 66's physician orders aff was to, "Fold and flush llowing removal / Two nurses dministration record (MAR) ified spacing for an a to document applying a new writing their initials, as well as a sen the staff removed and patches with "NURSE 1 INT ISE 2 INT" being provided for irses sign the witnessed sted by the physician orders. In a total of ten Fentanyl patch however, only four of the ten nurses signed the MAR to all was witnessed by 2 nurses. On 3/3/16, at 11:00 a.m. N)-E stated two nurses should witnessed the transdermal Both [nurses] are supposed to RN-E reviewed R66's February ed, "People aren't doing it," irses should be signing off on insure they are being disposed	F4	31	schedule accordingly to the trendin identified.	g	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245186	B. WING			C / 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE	03/	03/2010
GOLDEN	VALLET REHABILIT	ATION AND CARE CENTER		GOLDEN VALLEY, MN 55427		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 465 SS=E	removed transderm have a second nurs destroyed correctly patches, "Still could [of medication]." The consulting phasinterview several tirunable to be reached A facility Destruction dated 7/2015, ident patches should be removal, and "Two the destruction of the resident's Medication [MAR]." 483.70(h) SAFE/FUNCTIONALE ENVIRON The facility must prosanitary, and comform residents, staff and This REQUIREMENT by: Based on observative review, the facility from th	insultant (RNC)-A stated the ral narcotic patches should be sign off to make sure it was because the removed. In have some potential residue remacist was contacted for mes during the survey, but was red. In of Controlled Drugs policy sified used transdermal destroyed following their licensed nurses must sign for me used patch on the remacked patch on the remarked patch on the public. It is not met as evidenced ion, interview and document	F 4		d encrete rmrest aspected resident ed for	4/12/16

A. BUILDING		IPLETED				
		245186	B. WING _		I	C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	maintain a clean ar 1 residents (R90) who locomotion. Findings include: UNEVEN SURFACT R88's annual Minim 1/15/2016, indicate R114's quarterly MIR114 had intact cognitive and intact cognitive and intact cognitive are the building, there we electric-powered or were smoking. The approximately 10 fethe right of the exit sloped slightly upwarked with a worr the patio began. A downward from the area, was also mar painted stripe where section of concrete the patio, and was afrom the patio toward difference in the here.	dition, the facility failed to ad sanitary wheel chair for 1 of tho utilized a wheel chair for 2 droutlized a wheel chair for 3 droutlized a wheel chair for 3 droutlized a wheel chair for 4 droutlized a wheel chair for 5 droutlized a wheel chair for 5 droutlized droutlized droutlized and 12/21/2015, indicted droutlized droutlize	F 46	disrepair have been corrected. 3.Facility staff have been educe notifying maintenance department issues with uneven pation areast and wheelchairs being in property. Maintenance Director or designate conduct monthly audits of sideridentify any potential hazards. Maintenance Director or designate conduct random weekly audits wheelchairs x 4 weeks. Resurvill be reviewed through QAPI and QAPI team will adjust audit as appropriate.	ent of any /sidewalks er repair. gnee will walks to nee will of lts of audits committee	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	CON	E SURVEY MPLETED
		245186	B. WING _			C / 03 / 2016
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	During a subsequenthere were again reseated in their whe with their walkers prindependently naviregular walker, and walker up slightly in the entrance of the propelled a standar eaching the pation required a couple of the wheelchair of the surface was unseated in an electric the chair over the run in an interview on stated she "has not the pation, but has on the uneven ridg seen residents struidge with their indistated "I don't have chair, but there "is because a lot of permitted the surface when supervised." R114 over the area that is stated she had new or trip on the paver tries to "not go bey smoking."	ent observation at 4:19 p.m., residents who were smoking, rel chairs, or on a bench chair, or or at bench chair, and upon area, R45 independently or	F 46	65		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245186	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	CODE	1 00/	55/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 465	including those who chairs "four-wheele and some who use non-smokers. RN-assessed to be able ability to be outside residents required a them during specific had been no falls been no f	esidents" who used the area, or propelled their own wheel did walkers, regular walkers, no assist devices," and also a stated residents were es smoke, which included their the facility. RN-I also stated if supervision, staff went with cotimes. (RN)-I indicated there ecause of the uneven surface a. Incident reports from 10/1/2015 did there were no resident ulted in falls or accidents due ce on the outside patio area. On 3/3/2016 at 4:58 p.m., the nnel (MP)-A stated he was no concrete area, and indicated rise when the ground come e MP stated he felt there if the ridge was higher on the building," making it more hairs to get over it. The MP did not go down after spring, ling it and leveling it" and he king the stripes." Introduced their own wheel is a side of the stripes."	F 4	65			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	COM	TE SURVEY MPLETED
		245186	B. WING			C / 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, Z 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	IP CODE	700/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 465	was in bed with her R90's wheelchair her going around the riguisibly soiled with a substance. On 2/2's seated in the wheel arm rest in the dining subsequent observed R90 was seated at wheelchair continued tape on the right are wheelchair continued tape on the right are wheelchair exposing the arm rest cushion broken. During interviewed assistant (NA)-C obstated she was unabeen in place. NA-wheelchair exposing the arm rest cushion broken. During interviewed as a management of the province o	on 2/29/16, at 2:42 p.m. R90 wheelchair against the wall. ad visible white paper tape ght armrest which appeared nunknown, dark-colored 9/16, at 6:41 p.m. R90 was chair with the soiled taped ng room eating. During a ation on 3/1/16, at 8:08 a.m. the dining room table, and her ed to have the soiled paper mrest. on 3/2/16, at 1:37 p.m. nursing paserved R90's wheelchair and tware how long the tape had C removed the tape of the g a hard plastic perimeter of n which was cracked and erview on 3/2/16, at 1:39 p.m. urse (LPN)-A observed R90's ted the cracked perimeter was, mance should have been	F 4	-65		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DAT COM	E SURVEY IPLETED
		245186	B. WING			C 03/2016
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 03/	03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 465		on, and the repair personnel	F 4	65		

Printed: 03/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245186

B. WING

03/02/2016

NAME OF PROVIDER OR SUPPLIER

GOLDEN VALLEY REHABILITATION AND CAR

STREET ADDRESS, CITY, STATE, ZIP CODE

7505 COUNTRY CLUB DRIVE

X4) ID REFIX 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	K 000	1	
	FIRE SAFETY			
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 2, 2016. At the			
	time of this survey, Golden Valley Rehab and CC was found 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.			
	This 3-story building was constructed in 1972 and was determined to be of Type II (222) construction. It has partial basement and is automatic fire sprinkler protected throughout. The facility has fire alarm detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 1 and had a census of 1 at the time of the survey.			
	The requirement at 42 CFR, Subpart 483.70(a) is MET.			
		à		

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

TITLE

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