

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 25, 2022

Administrator Covenant Living Of Golden Valley Care & Rehab Ctr 5825 St Croix Avenue Golden Valley, MN 55422

RE: CCN: 245322

Cycle Start Date: May 12, 2022

Dear Administrator:

On May 12, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 241-7797

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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 12, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by November 12, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor — Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



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May 25, 2022

Administrator Covenant Living Of Golden Valley Care & Rehab Ctr 5825 St Croix Avenue Golden Valley, MN 55422

Re: State Nursing Home Licensing Orders

Event ID: LWD911

Dear Administrator:

The above facility was surveyed on May 9, 2022 through May 12, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 241-7797

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst

Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 06/23/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245322	B. WING			05/12/2022	
	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB CT	R	58	REET ADDRESS, CITY, STATE, ZIP CODE 25 ST CROIX AVENUE OLDEN VALLEY, MN 55422		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000			
	Appendix Z, Emerg Requirements, §483 during a standard re facility was IN comp						
F 000	signature is not req page of the CMS-25 correction is require acknowledge receip	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.		000			
	survey was conduction was all was found to be NC requirements of 42	2 a standard recertification ted at your facility. A complaint lso conducted. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	The following comp UNSUBSTANTIATE H5322083C (MN80 H5322084C (MN82 H5322085C (MN82	887) 2057)					
	as your allegation of the asyour allegation of the	f correction (POC) will serve of compliance upon the stance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will stion of compliance.					
	onsite revisit of you validate that substa	acceptable electronic POC, an refacility may be conducted to ntial compliance with the DER/SUPPLIER REPRESENTATIVE'S SIGI			TITLE		(X6) DATE

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

Electronically Signed

06/03/2022

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245322	B. WING				C 12/2022
NAME OF	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	
COVENA	NT LIVING OF GOLD	EN VALLEY CARE & REHAB CTI	R		325 ST CROIX AVENUE OLDEN VALLEY, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	Continued From pa	ge 1	FC	000			
F 656 SS=D	regulations has been Develop/Implement CFR(s): 483.21(b)(Comprehensive Care Plan	F 6	556			6/3/22
	§483.21(b)(1) The fimplement a compression for each resident rights set for §483.10(c)(3), that objectives and time medical, nursing, an needs that are ident assessment. The conference of the following of the following for maintain the resident services that are quired under §483.10, includer §483.24, §48 provided due to the under §483.10, includer §48	t are to be furnished to attain dent's highest practicable of psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	`	(X3) DATE SURVEY COMPLETED C 05/12/2022	
		245322	B. WING			
	NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CT			STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	5.475	
F 656	Continued From p	age 2 cies and/or other appropriate	F 65	56		
	entities, for this put (C) Discharge plan plan, as appropria requirements set if section. This REQUIREME by: Based on intervie facility failed to ent completed as iden residents (R26) re Findings include: R26's admission in 4/12/22, identified impairment and re with most activities During interview of stated she felt she fluids and was won help improve her stated she felt she fluids and was won help improve her stated she felt she fluids and was won help improve her stated she felt she fluids and was won help improve her stated she felt she fluids and was won help improve her stated she help improve her stated she fluids and was won help improve her stated she hel	• • • •		Covenant Living of Golden Valley Cal and Rehabilitation respectfully submitthis plan of correction as its allegation compliance. The following combined pof correction and allegation of complia is not an admission to any of the alleg deficiencies or violations and is submat the request of the Minnesota Department of Public Health. Prepara and execution of this response and plof correction does not constitute an admission or agreement by the providithe truth of the facts alleged or conclusions set forth in the statement deficiencies. F656 483.21(b)(1) Develop/Implement Comprehensive Care Plan According to the statement of deficien (2567) "Based on interview and docur review, the facility failed to ensure we monitoring was completed as identified the care plan for 1 of 2 residents (R26 reviewed for weight loss. 1. Corrective actions which will be accomplished for those residents four have been affected by the alleged deficient practice a. R26 i. R26 discharged from the facility of 5-13-2022	s of plan ance ged itted ation an der of cies ment ight ed on 5)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X3) DATE SURVEY COMPLETED	
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		245322	B. WING _		05/1	2/2022	
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
COVENA	NIT I IVING OF GOL	DEN VALLEY CARE & REHAB CTI	ь I	5825 ST CROIX AVENUE			
COVENA	INT LIVING OF GOL	DEN VALLET CARE & REHAB CTI		GOLDEN VALLEY, MN 55422			
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F 656	Continued From p	page 3	F 6	56			
F 656	as much discus recommend daily accuracy. Both paractic daily weight request the R26's Care Plan I identified R26 was tatus and uninterlisted several goals "Weight to remain no sig[nificant] was several intervention of the	sed w/ resident and daughter, weights to obtain weight arties agreed. Daily weights MD [medical doctor] notified of est." Report, printed 5/12/22, s at risk of impaired nutritional ntional weight loss. The report als for R26 which included, a stable 271 # [lbs] +/- 3% with [weight] changes," along with ons to help R26 meet these DAILY WEIGHT IN PLACE IGHT ACCURACY." Resident Vital Sign Report, dentified R26's collected and in the medical record. This wing since the daily weights I/or care planned by the RD: Ibs. ot Scheduled." ot Scheduled." ot Scheduled." ot Scheduled."		2. How the facility will ident residents having the potential affected by the same deficient. All residents with care promonitoring may be affected deficient practice – Complet -2022 b. The Director of Nursing reviewed all residents in the weight issues and implement clinical follow up– Completic 2022 3. What measures will be por systemic changes made, the deficient practice will not a. The Director of Nursing policy and procedures associated and procedures are procedures associated and procedures are pro	al to be ent practice planned weight by the alleged tion date: 5-30 and Dietician facility for any not appropriate on date: 5-30- put into place, to ensure that to occur reviewed the ciated with the clicy was andards of 1-2022 gnee educated recorrect ollow up. 6-3- aitor its that the		
	5/4/22 - 253.00 lb 5/6/22 - "ADL Not	S.		will not recur a. The Director of Nursing			
	5/11/22 - "ADL NO			will audit 15 residents on dai each week for four weeks. T	ily weights		
	refusals, for the re on the report. Fur reviewed and lack daily weights had	corded weights, or documented emainder of the days not listed ther, R26's medical record was ked any further evidence these been obtained and documented uested and/or ordered by the ned on 4/26/22.		residents on daily weights eventhe next three months. Cont the daily weight residents queight for the next year. b. MDS staff to audit 15 remonth to ensure all weight dis correct, entered and documents. 5. Completion Date: Friday	very month for inue to audit uarterly and esidents each documentation mented.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245322	B. WING		05/12/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	5	TREET ADDRESS, CITY, STATE, ZIP CODE 825 ST CROIX AVENUE SOLDEN VALLEY, MN 55422		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 656	When interviewed nursing assistant (appetite" and typic meals. NA-A stated daily weight, and excollected, recorded the nurse. NA-A adhad sustained any to the nursing hom. When interviewed registered nurse use on a daily weight and reconstruction of the nursing hom. When interviewed registered nurse use of the nursing hom. When interviewed stated she was weights had not be felt the nursing hom. When interviewed stated R26 was we weight loss" which R26 and her family recommendation to be the started on 4/26/22 weights] have not for the started on 4/26/22 weights]	on 5/11/22 at 10:19 a.m., NA)-A stated R26 had a "good ally finished all her provided d she was aware R26 was on a xplained it was supposed to be d in the computer, and given to ded she was unaware if R26 weight loss since she admitted e. on 5/12/22 at 9:44 a.m., nit manager (RN)-C stated R26 ght and the NA(s) should be cording it in the computer. The lieved it was happening but w how consistent it's been." It was aware some orders for daily sen completed and voiced she me was "making strides" in action and recording of them. on 5/12/22 at 9:56 a.m., RD-A eighed and showed "significant resulted in the discussion with a member and the complement a daily weight to m. The order for daily weights and RD-A verified, "They [daily been done consistently." and she felt, R26 was stable,	F 656	2022		
	A facility policy on weight manageme provided.	weight monitoring and/or nt was requested but not Resuscitation (CPR)	F 678			6/3/22

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245322	B. WING _			C 1 2/2022
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	R	STREET ADDRESS, CITY, STATE, ZIP CO 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	DDE	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 678	F 678 Continued From page 5 §483.24(a)(3) Personnel provide basic life		F 6	78		
	support, including such emergency medical related physician advance directive. This REQUIREMS by: Based on intervie facility failed to en medical record entreatment were clawould be implemed for 1 of 2 resident directives. Findings include: R293's HealthPandated 5/7/22, idented 5/7/22, idented to summary listed. The summary listed "Assessment/Planincluded, "Code Stresuscitation]." R293's electronic printed 5/12/22, idented to summary listed to summary listed. The summary listed to summary	CPR, to a resident requiring care prior to the arrival of cal personnel and subject to orders and the resident's s. ENT is not met as evidenced ew and document review, the sure conflicting directives and arified to ensure resident wishes ented in an emergency care and arified to ensure resident wishes ented in an emergent situation s (R293) reviewed for advanced the succession of the status: Discharge Summary, attified R293 admitted to the hip pain associated with a hip I a discharge date of 5/7/22. The status: DNAR [do not attempt that is a section labeled, and the status: DNAR [do not attempt the status: DNAR [do not attempt the status and status an		Covenant Living of Golden and Rehabilitation respectful this plan of correction as its compliance. The following confection and allegation of is not an admission to any of deficiencies or violations and at the request of the Minness Department of Public Health and execution of this respons of correction does not constitute admission or agreement by the truth of the facts alleged conclusions set forth in the state deficiencies. 483.24(a)(3) Cardio-Pulmon Resuscitation According to the statement of (2567) "Based on interview a review, the facility failed to e conflicting directives and meentries for emergency care a were clarified to ensure reside would be implemented in an situation for 1 or 2 residents reviewed for advanced directive actions which accomplished for those residence have been affected by the all deficient practice	lly submits allegation of ombined plan of compliance if the alleged dis submitted ota. Preparation is and plan itute an the provider of or statement of ary of deficiencies and document nsure edical record and treatment dent wishes emergent (R293) etives. It will be dents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C 05/12/2022	
		245322	B. WING			
	PROVIDER OR SUPPLIED	DEN VALLEY CARE & REHAB CT	R	STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE	
F 678	However, located in R293's hard chart was an undated, signed Physician Orders for Life-Sustaining Treatment (POLST) which had a handwritten "X" placed next to an option which indicated, "Attempt Resuscitation / CPR (Note: selecting this option requires selecting "Full Treatment" in Section B)." The following section, "B," outlined several options for medical treatments to be completed if the patient has a pulse or is breathing including, "Full Treatment," and, "Selective Treatment," and, "Comfort-Focused Treatment (Allow Natural Death)." This had a black-colored handwritten "X" placed next to the option which directed comfort-focused treatment which was in conflict with the POLST instructions from the previous section which directed selecting CPR required "Full Treatment" be selected. The POLST was signed by FM-D and a nursing home staff member; however, was unsigned by a medical provider.		F 67	 a. R293 i. R293 has had their Advance information reviewed and updath has signed the documentation - Completion date: 5-10-2022 2. How the facility will identify residents having the potential to affected by the same deficient page 1. 	ted, NP - other o be oractice	
				a. All residents with Advance may be affected by the alleged practice b. The Director of Nursing reviewed residents in the facility for any Advance Directives and implement appropriately follow up - Completion of 2022 3. What measures will be put or systemic changes made, to extend the deficient practice will not on a. Director of Nursing reviewed resident chart for Advance Director of Director and accuracy – Condate: 5-10-2022	Directives deficient iewed all ate: 5-10- into place, ensure that cur d all ctive	
	evidence these coclarified with R293 correct wishes wo was found without On 5/10/22 at 8:3 R293 admitted from fracture and was As a result, the hoto make R293 a Ewas to stop breath FM-D stated he renursing home abordowever, could not be stop to the state of the sta	ecord was reviewed and lacked onflicting documents were and, or their POA, to ensure their ould be implemented if R293 and a pulse and/or not breathing. 7 a.m. R293's FM-D stated om the hospital after a hip in the "late stages" of dementia. Ospital team and FM-D elected DNR and "just let her go" if she ming or be found without a pulse. Ecalled talking to a nurse at the out this upon R293's admission, of recall any education on the EM-D stated he believed the		b. Audit all admission charts in PDPM meeting for correct and Advance Directives – Completic 3-2022 c. The Director of Nursing or creviewed the policy and proced associated with Advanced Direct Completion date: 6-1-2022 d. Nursing Educator or design educated nursing staff on the nucorrect Advance Directive docu care, and follow up – Completic 3-2022 4. How the facility will monitor corrective actions to ensure the deficient practice is being corre	completed on date: 6- designee ures ed for mentation, on date: 6- its its it the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		245322	B. WING			C 12/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	R	STREET ADDRESS, CITY, STATE, ZIP (5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	CODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 678	chart and was unabeen checked. FN and R293 should DNR. When interviewed registered nurse (assigned to care fonly worked at the RN-A stated if a reapulse or not breimmediately review directions on how allow death). RN-A location he had be when he started a would review the RN-A explained if found without a pucheck R293's face he would not implereviewed R293's face he	the POLST located in R293's aware CPR (i.e., full code) had M-D verified this was incorrect be recorded on the POLST as a lon 5/10/22 at 9:37 a.m. RN)-A stated he was the nurse for R293, and explained he had a nursing home a few weeks. Esident would be found without athing, then he would we their "face sheet" for to respond (i.e., full code or A stated he could not recall what een directed or trained to check at the nursing home, however, face sheet strictly out of habit, approached with R293 being alse or not breathing, he would esheet which directed DNR and ement CPR. RN-A then EMR and completed POLST are conflicting," RN-A stated it ensure advance directive les in all locations (i.e., EMR rwise, in the event of cardiac or the staff "don't know what to complete the pols of the director of the staff "don't know what to complete the staff the pols of the pols		will not recur a. Director of Nursing or caudit 15 residents with Adv Directives every week for for then every month for the nemonths. Continue quarterly reviews PRN for the next yb. Director of Nursing or crefer Advanced Directive at QAPI committee to identify recommendations and to e compliance. 5. Completion Date: Frida 2022	anced our weeks, ext three reviews and ear. designee to udits to the trends, make nsure ongoing		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245322	B. WING _			C / 12/2022
	NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTF			STREET ADDRESS, CITY, STATE, ZIP COD 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	•	
(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 APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
for process the creation of th	perienced cardial perienced cardial perienced cardial perienced cardial perienced cardial perienced cardial perienced with a suscitation with a suscitation with a suscitation with a suscitation and a suscitation with a suscitation and a suscitati	m was then sent to the medical are. When a resident ac or respiratory arrest and ansigned, it should be their physician orders which any staff should ultimately go by shes. The DON reviewed a EMR and stated the antation and records made it that R293's wishes were and clarification from the family was be Directives policy, dated a resident's written advanced a reviewed upon admission by director or designee. If a nabout an advance directive played prominently in the policy outlined, the policy outlined, the povide information to the presentative regarding the atus, treatment options and so, and the resident had the tement adding, "A resident will anst his or her own wishes." In the procedures - Resuscitation policy, dated and all is found unresponsive and adual is found unresponsive normally, CPR should be vious signs of clinically i.e., decapitated) or, " it is not Resuscitate (DNR) order chibits CPR and/or external for that individual." However, my further information or to check in the medical record		78		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	` '	(X3) DATE SURVEY COMPLETED	
		245322	B. WING _		C 5/12/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	R	STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422		
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F 678	for this information Resuscitate Order CPR would not be in effect. These or physician and "	Further, a provided Do Not policy, dated 4/2017, identified used when a DNR order was ders were to be signed by the maintained in the resident's sing a state-approved form	F 67	8		
F 684 SS=D	applies to all treatrest facility residents. Exassessment of a retained that residents receasing accordance with practice, the composer plan, and the	f care fundamental principle that nent and care provided to eased on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced	F 68	4	6/3/22	
	review, the facility inserted central carmonitored and charten and charten and charten are to complication for 1 for intravenous (IV). Findings include: A National Library article, peer-review as a long, thin tube the upper arm which near your heart." medications into the control of the c	ration, interview, and document failed to ensure a peripherally theter (PICC) dressing was inged in accordance with the reduce the risk of of 1 resident (R26) reviewed of 1 resident (R26) reviewed of 2021, identified a PICC inserted through a vein into 1 ch " goes into a large vein This helped to carry nutrients or 1 in the red and 2021, identified a PICC of the article labeled, "Dressing of the article labeled, "Dressing and 2021 in the article labeled, "Dressing 2021 in the article article labeled, "Dressing 2021 in the article articl		Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plat of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F684 483.25 Quality of Care	n ee d n	

	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	EN VALLEY CARE & REHAB CTE	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)	ULD BE	(X5) COMPLETION DATE	
F 684	reduce the risk of insertion site dry archange the dressin R26's admission M4/12/22, identified impairment and redwith most activities the MDS identified medication while a On 5/9/22 at 3:47 pbed while in her roolline inserted into he covered with a clear was slightly red-collinact with minor perhowever, a piece of along the bottom of "05/01/22 [eight dargetting antibiotics the sure when it was good R26 stated she was were changing the insertion site but depotential infection (difficulty). R26's Standing Ord Facilities, dated 1/6 labeled, "IV Line Market Line Line Market Line Line Line Line Line Line Line Line	d a dressing was used to effection and keep the PICC and clean, directing "You should g about once a week." inimum Data Set (MDS), dated R26 had severe cognitive quired extensive assistance of daily living (ADLs). Further, R26 received intravenous (IV) resident at the nursing home. o.m. R26 was observed lying in om. R26 had a visible PICC er right inner arm which was ar dressing. The insertion site ored and the dressing was beling around the perimeter; f paper tape was present of the dressing which read, ys prior]." R26 stated she was hrough the PICC and was not oing to be removed. Further, as unsure how often the staff clear dressing over the enied any symptoms of i.e., chills, fever, respiratory ders for Skilled Nursing S21, identified a section anagement," which directed, ine and site care per facility	F 6		nterview, y failed to entral conitored the isk of (R26) re. I be is found to ed on 5-11-fection for 5-11-fection for 5-11-fection for 5-11-fection for 5-11-fection for 5-11-fection for 5-11-fectice for 5-11-fec		
	included ceftriaxon IV twice a daily for	der Sheet, dated May 2022, e (an antibiotic) 2 gram (gm) 42 days (starting 4/6/22), ent which read, "IV THERAPY		date: 5-10-2022 b. The Director of Nursing or of reviewed the policy and procedulassociated with care and manage	esignee Ires		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	SUMMARY STA	EN VALLEY CARE & REHAB CTI	ID	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422 PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	`	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)		COMPLETION DATE
F 684	[diagnosis] for med completed "by shift's subsequent physicial identified R26's inference R26 was to continu 5/12/22 and have the However, none of the outlined when or he line dressing to ensiline and reduce the infection. R26's Geriatrics Forence A/11/22, identified Forence and was he with a rapid decline diagnosed with ence empyema with associated (inflammation of the infection). The note found to have a DV her arm with the Ple emergency department of the infection of the in	nce, dressing, flushes, IV type, ication, temps," to be starting on 4/6/22. R26's an order, dated 5/10/22, ection had improved; however, ee the IV antibiotics through he PICC removed afterward. He reviewed physician orders ow often to change R26's PICC ure adequate protection of the risk of contamination or Ilow Up Visit note, dated R26 had a history of high blood hospitalized for several days in mental status, being ephalopathy and subdural	F 6	PICC Lines – Completion date c. Director of Nursing or desi educated the nursing staff on t correct line documentation, dre changes, site care and follow to Completion date: 6-3-2022 4. How the facility will monito corrective actions to ensure the deficient practice is being corre will not recur a. Director or Nursing or desi audit 15 residents for PICC line every week for four weeks, the month for the next three month Continue quarterly reviews and PRN for the next year. b. Refer PICC line audits to the committee to identify trends, m recommendations and to ensu compliance. 5. Completion Date: Friday, 3 2022	need for ssing p — its the cted and lines nevery s. reviews le QAPI ake re ongoing	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB CTI	₹	STREET ADDRESS, CITY, STATE, ZIP 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422				
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F 684	a.m., R26 continue present in her right clear dressing cont present along the pwas now removed blue-colored, illegible the tape had been this observation, reknocked and entere the scheduled antible the PICC line dress changed it recently. When interviewed explained PICC line dress changed every three however, again reit physician order for tracked and docum the medical record; she was not sure if out for R26 in the pR26's treatments a R26's PICC line dress charting with IV line changes, and she minfection control and weeks prior; however follow-up or new did RN-B again stated changed in accordance.	observation on 5/11/22 at 7:55 d to have the PICC line arm with a clear dressing. The inued to have slight peeling erimeter; however, the tape and the dressing had faint ole writing on the bottom where prior. Immediately following gistered nurse (RN)-B ed R26's room to administer piotic. RN-B was questioned on sing and voiced she had not	F 6	84				
	were no orders, the	en "the facility has to ng" to ensure it's changed and						

NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DEFICIENCY)			245322	B. WING _		05	C / 12/2022	
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 13 tracked. R26's medical record was reviewed and lacked any evidence the PICC line dressing had been changed after 4/8/22 when the new PICC was placed in the ED. On 5/11/22 at 9:03 a.m. the registered nurse unit manager (RN)-C was interviewed and explained PICC line dressings should be changed every seven days unless otherwise directed in the physician orders. R26 admitted to the nursing home with the PICC line in place and continued to receive IV antibiotics through it. RN-C stated with the dressing being first observed with a 5/1/22 date, it had likely been missed and not changed on the weekly basis it should be. Further, RN-C stated all PICC line dressing changes should be recorded in the medical record and it was important to ensure the dressing was actually being changed and recorded as "the risk of infection is huge." When interviewed on 5/12/22 at 10:15 a.m. the infection control and prevention registered nurse (RN)-D stated the facility' policy was to change a PICC line dressing 'weekly' and should be				TR	5825 ST CROIX AVENUE	IP CODE		
tracked. R26's medical record was reviewed and lacked any evidence the PICC line dressing had been changed after 4/8/22 when the new PICC was placed in the ED. On 5/11/22 at 9:03 a.m. the registered nurse unit manager (RN)-C was interviewed and explained PICC line dressings should be changed every seven days unless otherwise directed in the physician orders. R26 admitted to the nursing home with the PICC line in place and continued to receive IV antibiotics through it. RN-C stated with the dressing being first observed with a 5/1/22 date, it had likely been missed and not changed on the weekly basis it should be. Further, RN-C stated all PICC line dressing changes should be recorded in the medical record and it was important to ensure the dressing was actually being changed and recorded as "the risk of infection is huge." When interviewed on 5/12/22 at 10:15 a.m. the infection control and prevention registered nurse (RN)-D stated the facility policy was to change a PICC line dressing "weekly" and should be	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
treatments of the medical record. RN-D reviewed the medical record and stated the dressing change would be a separate order and treatment aside from the general monitoring one listed. RN-D stated it was important to ensure the dressing was changed on a weekly basis to help reduce the risk of infection and added she could not recall any staff reaching out to her with concerns about IV management in the past weeks. Further, RN-D stated education was just provided to the nurses during a skills fair the	F 684	R26's medical red any evidence the changed after 4/8 placed in the ED. On 5/11/22 at 9:03 manager (RN)-C verification orders, home with the PIC receive IV antibiot the dressing being date, it had likely lon the weekly bas stated all PICC line recorded in the mimportant to ensure being changed and infection is huge." When interviewed infection is huge." When interviewed infection is huge." When interviewed infection control at (RN)-D stated the PICC line dressing entered and record treatments of the the medical record change would be aside from the general any stated it was dressing was changed and recall any staff concerns about IV weeks. Further, R	cord was reviewed and lacked PICC line dressing had been /22 when the new PICC was a.m. the registered nurse unit was interviewed and explained gs should be changed every so therwise directed in the R26 admitted to the nursing CC line in place and continued to tics through it. RN-C stated with g first observed with a 5/1/22 been missed and not changed sis it should be. Further, RN-C are dressing changes should be edical record and it was re the dressing was actually and recorded as "the risk of a condition or egistered nurse facility policy was to change a g "weekly" and should be reded in the physician orders and medical record. RN-D reviewed and stated the dressing a separate order and treatment neral monitoring one listed. It is important to ensure the need on a weekly basis to help infection and added she could be reaching out to her with a management in the past incomposition of the past incomposition was just incomposition.		34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI			(X3) DATE SURVEY COMPLETED	
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F 697	A provided Central Changes policy, datransparent, semi-policy were to be changed needed. The date at change, objective of and and complication were to be recorded Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mathematical The facility must emprovided to resident consistent with provided to resident consistent with provided to resident consistent with provided the residents' of This REQUIREMED by: Based on observative with the facility for review, the facility for review of the pain in the reviewed for pain in the Findings include:	gain, verified the dressing weekly. Venous Catheter Dressing ted 4/2016, identified permeable membrane dressing devery 5 - 7 days and as and time of the dressing description of the insertion site, ons from the dressing change d in the medical record. anagement. anagement such services, fessional standards of practice, person-centered care plan, goals and preferences. NT is not met as evidenced tion, interview, and document failed to ensure physician and orders were clarified and de pain medication and r 1 of 2 residents (R297)	F 69		s of plan ance ged itted	
	R297 admitted to the of the nursing home hospital with an additional statement of the spital state	ne transitional care unit (TCU) e in early May 2022 from the mission diagnosis of displaced acture of the right femur (leg		of correction does not constitute an admission or agreement by the providing the truth of the facts alleged or conclusions set forth in the statement deficiencies. F697	der of	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		\ \ /	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	1 Z/ Z U Z Z	
10/11/12	TO TIBEL COLL COLL EIGH			5825 ST CROIX AVENUE	J _		
COVENA	NT LIVING OF GOLI	DEN VALLEY CARE & REHAB CT	₹				
				GOLDEN VALLEY, MN 55422			
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F 697	Continued From p	age 15	F 6	97			
F 697	R297's Individual R 5/3/22, identified R admission to the natural place R297 had actual place R297 had actual place remainder of the pain managem and not completed. On 5/9/22 at 6:37 wheelchair while in was extended outwaiting for a heat place to see the prior to admiss as "pins and need down her leg into be required by the physician assistant family request. The poor pain control of acetaminophen or R297's listed pain including ace	Resident Care Plan, dated R297's initial care needs upon Jursing home. The section of Jed, "Pain Control," identified Jeain in her right leg. However, the section, including spaces to Jent interventions, was left blank of Jent Jent Jent Jent Jent Jent Jent Jent		483.25(k) Pain Management According to the statement o (2567) "Based on observation and document review, the facensure physician recomment orders were clarified and add provide pain medication and comfort for 1 of 2 residents (I reviewed for pain management 1. Corrective actions which accomplished for those resid have been affected by the all deficient practice a. R297 i. The Director of Nursing of reviewed R297 for any adverse related to the pain medication initiation. R297 has had their medications, information reviupdated. NP has signed the documentation – Completion 2022 2. How the facility will identified the pain medications are deficier a. All residents requiring pamanagement may be affected alleged deficient practice. b. Director of Nursing or de review all residents in the face pain medications and implem appropriate clinical follow up 3. What measures will be por systemic changes made, the deficient practice will not a. Director of Nursing or de review all residents made, the deficient practice will not a. Director of Nursing or de review all residents made, the deficient practice will not a. Director of Nursing or de review all residents made, the deficient practice will not a. Director of Nursing or de review all residents made, the deficient practice will not a. Director of Nursing or de review all residents made, the deficient practice will not a. Director of Nursing or de review all residents made, the deficient practice will not a.	f deficiencies n, interview cility failed to dations and lressed to promote R297) ent. will be ents found to eged or designee se effects n order pain ewed and date: 5-10- fy other I to be nt practice in d by this signee to cility for any nent ut into place, o ensure that occur		
	reported the pain in night, will schedule	s also bad in the middle of the a dose for bedtime." The note section labeled, "Assessment		consulted with the Pharmacis outstanding recommendation follow up of pain medications	st on any is for the		

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		\ \ /	E SURVEY PLETED
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			_	5825 ST CROIX AVENUE		
COVENA	NT LIVING OF GOLI	DEN VALLEY CARE & REHAB CT	R	GOLDEN VALLEY, MN 55422		
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F 697	Continued From pa	age 16	F 6	97		
F 697	and Plan," which of recommendations twice a day (every seven days then continuous the (PA) orders from the (PA) orders from the (PA) orders from the (PA) orders from the thip for 12 hours. 1) Lidocaine 4% partight hip for 12 hours. 2) Diclofenac topic medication) applied day; and, 3) Apply ice to the increments four ting. The completed physical properties of the completed physical properties.	including oxycodone 2.5 mg morning and bedtime) for onsider a reduction. corresponding Twin Cities heet, dated 5/9/22, identified om the 5/9/22 visit. These atches to be applied to R297's ars, then removed for 12 hours; cal gel 1% (an anti-inflammatory d to the right hip four times a right hip in 20 minute me a day for three days. ysician orders did not include		Completion date: 5-23-2022 b. Director of Nursing or d reviewed the policy and pro associated with pain medica physician progress notes – date: 6-1-2022 c. The Director of Nursing educated the nursing staff of correct progress note follow documentation, care and fo Completion date: 6-3-2022 d. Progress notes will be r Medical Records for any ne in ICD codes. Medical Record sign off on the progress not the MDS staff. MDS staff to notes for any medication or appointments or treatments need follow up. MDS staff w the progress notes. When the two signatures to verify a do-	esignee cedures ations and Completion or designee on the need for up, llow up — reviewed by w or alteration ords staff will es then give to audit progress ders, that may vill sign off on he note has puble check it	
	any orders for oxycodone despite being listed in the plan of the corresponding progress note by the PA, and despite having been reviewed and discussed with R297's family member to help R297 have better pain control and potentially participate better with therapies. The orders were dated with a handwritten 5/9/22 by the nursing home staff. R297's subsequent Resident Vital Sign Report (for pain), dated 5/10/22 to 5/11/22, identified R297 rated her pain between a 1.0 and 2.0 (on a scale of 0-10 with "10" being the worst rating). During subsequent observation on 5/10/22 at 2:11 p.m. R297 was lying in bed while in her room. R297's eyes were closed and she appeared comfortable with no obvious grimacing or physical			record. 4. How the facility will more corrective actions to ensure deficient practice is being or will not recur a. Director of Nursing or daudit 15 residents with pain every week for four weeks, month for the next three more Continue quarterly reviews PRN for the next year. b. Director of Nursing or daudit 15 resident physician every week for four weeks, month for the next three more continue quarterly reviews and the continue quarterly reviews and the present three more continue quarterly reviews and the present three more continue quarterly reviews and present three more continues are continued to the present three continues are continued to the p	nitor its that the orrected and esignee to medications then every onths. and reviews esignee to progress notes then every onths.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 697	registered nurse (to care for R297 at the nursing home a "pain patch" and RN-A stated there oxycodone. RN-A note, and correspond being listed on the address R297's pathe process in pla completed physici unaware who, if at the physician prog "never had the chas stated he was una corresponding ord to ensure the corr implemented. RN- corresponding ord to remove "confus" "actual plan" was for the resident. When interviewed registered nurse u physician orders w coordinator (HUC) electronic medical there was poor co nursing home and often staff were "n seen. RN-C expla assigned or direct incoming physicia		F 69	c. Refer pain/progress in QAPI committee to identifications and to compliance. 5. Completion Date: Frid 2022	fy trends, make ensure ongoing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245322	B. WING _			C /12/2022
	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB CT	R	STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION CORRE	ULD BE	(X5) COMPLETION DATE
F 758	and she expressed example of why the communication with and nursing staff. It important to ensure and orders were cleare" to the patient and potential error had the surveyor nursing (DON) was had investigated the dictated the progred discussion with R2 the order for the oxidicated the progred discussion with R2 the order for the oxidicated the progred discussion with the PR297 was harmed however, the PA was medication as interesting implemented reviewed the process with the medical reforward," they were notes and orders for stated it was important progress notes we consistency to help potentially missed. A facility' policy on physician order clant provided.	I this served as another by needed to improve the the medical provider group further, RN-C stated it was a conflicting or unclear notes arified to provide "continuity of and voiced this inconsistency would not have been identified of brought it to their attention. 6 a.m. the interim director of a interviewed and stated she issue. The PA rounded and so note after having a 197's family member, then sent excodone to the incorrect inbox and be received by the nursing atted she discussed the A and neither of them believed as a result of the incident; anted to still start the adequate pain control was a readequate pain control was a result of the incident; anted to still start the adequate pain control was a result of the incident; anted to still start the adequate pain control was a result of the incident; anter a dequate pain control was a result of the incident; anter the DON stated she are successful to begin looking at the proposition of the proposi				6/3/22
	CFR(s): 483.45(c)	•				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245322	B. WING		O !	C 5/12/2022
	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB CT	R	STREET ADDRESS, CITY, STATE, ZIP CO 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	<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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	affects brain activitic processes and behout are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compressed on a compression, the facility §483.45(e)(1) Reside psychotropic drugs unless the medicate specific condition as in the clinical record services of the services o	tropic Drugs. ychotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following the thensive assessment of a must ensure that dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented d; dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and	F 7	58		
	are limited to 14 da §483.45(e)(5), if the prescribing practition	orders for psychotropic drugs ys. Except as provided in attending physician or oner believes that it is PRN order to be extended				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245322	B. WING			1 2/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	R	STREET ADDRESS, CITY, STATE, ZIP CO 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	•		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	sassion and portion of daily living (ADL R26's Physician Of included buspirone milligrams (mg) twantidepressant me and lorazepam (armg twice a day as had a listed start of the duration of the control o	de or she should document their sident's medical record and on for the PRN order. Norders for anti-psychotic of 14 days and cannot be defetted attending physician or sioner evaluates the resident for so of that medication. ENT is not met as evidenced which and document review, the sure as-needed (PRN) dications were limited to 14 days attended by the medical provider to and reduce the risk of for 5 residents (R26) reviewed dedication use. Minimum Data Set (MDS), dated R26 had anxiety disorder, dest-traumatic stress disorder R26 displayed severe cognitive enstrated no behaviors of care or delusions), and defended assistance with most activities assistance with most activities assistance with most activities and defended (PRN). The lorazepam defended (PRN). The lorazepam late of 4/6/22.		Covenant Living of Golden and Rehabilitation respectfuthis plan of correction as its compliance. The following confection and allegation of some and an admission to any ordeficiencies or violations and at the request of the Minnes Department of Public Health and execution of this responsof correction does not constituding admission or agreement by the truth of the facts alleged conclusions set forth in the state deficiencies. F758 483.45(c)(3)(e)(1)-(5) Free for Unnecessary Psychotropic for Use According to the statement of (2567) "Based on interview are review, the facility failed to eas-needed (PRN) psychoact medications were limited to use or re-evaluated by the more provider to ensure necessity the risk of complication for 1	Ily submits allegation of ombined plan of compliance f the alleged d is submitted ota a. Preparation is e and plan itute an the provider of or statement of or statement of deficiencies and document insure tive 14 days of nedical and reduce of 5		
	R26's Care Plan R	Report, printed 5/12/22,		residents (R26) reviewed for			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	E SURVEY PLETED
		245322 B. WING			05/12/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	R	STREET ADDRESS, CITY, STATE, ZIP (5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 758	on a regular basis which read, "Symptontrolled with min 90 days." The carrinterventions to he providing activities the medications, a atmosphere. R26's April 2022 May 2022, identified for the month as a staff. This identified which identified it 4/29/22 with the recorded or direct active order for the had received no defar. However, both recorded or direct medication. R26's Interim Medication.	is receiving antianxiety drugs s," and listed a goal for R26 ptoms of anxiety will be nimal side effects over the next e plan listed several elp R26 meet this goal including s, monitoring for side effects of and providing a quiet Medications report, dated R26's consumed medications signed out by the nursing home ed R26's lorazepam PRN order was administered once on esults being recorded, "Pain = stered." There was no recorded s or resolution on the report. In ay 2022 Medications report, ntified R26 continued to have an e PRN lorazepam, however, loses in the month period thus n of these reports lacked any ed stops date for the PRN dication Regimen Review, dated the consulting pharmacist had hysician orders and made ndations including, "PRN ers needs a 14 day stop date. e-evaluate continued need for ication(s): Lorazepam." The was signed on 4/22/22 by	F 7	medication use. 1. Corrective actions which accomplished for those resident practice a. R26 i. Pharmacist consulted of for specific recommendation ii. Medication was discontable 2022 by the medical providiii. R26 discharged from the 13-2022 2. How the facility will idea residents having the potental affected by the same deficinal and Director of Nursing or consulted with recommendations and imperapropriate clinical follow undate: 5-30-2022 3. What measures will be or systemic changes made the deficient practice will not an Director of Nursing or consulted with the Pharmacoutstanding recommendatifollow up of psychoactive in Completion date: 5-23-202. b. The Director of Nursing reviewed the policy and proassociated with psychoactic — Completion date: 6-1-202 c. The Director of Nursing educated all nursing staff or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and follow up — Completion 2022 d. Director of Nursing or correct psychoactive docur and	on 5-10-2022 on tinued on 5-10- ler he facility on 5- ntify other tial to be lent practice designee e facility for any nedication lement up — Completion e put into place, to ensure that ot occur designee cist on any ons for the nedications — 2 g or designee ocedures we medications 22 g or designee on the need for mentation, care in date: 6-3-	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	E SURVEY PLETED
		245322	B. WING _			C 12/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COVENA	NT LIVING OF GOLD	EN VALLEY CARE & REHAB CTE	٦	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	since it was ordered prior). Further, there medication use had 14-day required timestop date determined concern documented pharmacist on their on 4/6/22. When interviewed registered nurse (Redisplay any anxiety described her as "particular RN-B reviewed R26 in the electronic recontinued to have reavailable for adminuation unsure when, or if, for the medication, aware most PRN particular stopped or have nethowever, she did nallor lorazepam specificated added, "I didn't ever [lorazepam] to be had reviewed R26's acknowledged therefor the PRN lorazepam; it's use had been reprovider. As a resumessage out to the addressed. RN-C remedication regiment explained those reproviders are provider.	tside of the 14-day period d on 4/6/22 (over 30 days e was no evidence the d been extended outside of the reframe (i.e., 60 days) or had a red, despite the identified red by the consulting redication regimen review on 5/11/22 at 1:21 p.m. RN)-B stated R26 did not retty calm and pleasant." So current medication orders cord and verified R26 PRN lorazepam ordered and ristration. RN-B stated she was a stop date was determined RN-B explained she was sychotropic's needed to be rew orders written after 14 days; ot know "the protocol" for how ally was addressed. RN-B n know she was on Ativan	F 7	consulted with PharMerica for currecommendations related to psycrecommendations – Completion of 23-2022 e. Director of Nursing met with the medical providers and the Medical Director to educate them on their proper follow up pharmaceutical recommendations-Completed 06-4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur a. Director of Nursing or designed audit 15 residents with psychoactimedications every week for four withen every month for the next three months. Continue quarterly review reviews PRN for the next year. b. MDS staff or designed to audicate plans each month for the compsychoactive medication interventies and month. c. Refer psychoactive audits to the committee to identify trends, mak recommendations and to ensure compliance. 5. Completion Date: Friday, Jun 2022	hoactive date: 5- he led for 1.01-2022 he ed and 2.2 ed and 2.2 ed and 3.2 ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245322	B. WING _		05	C / 12/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CT	R	STREET ADDRESS, CITY, STATE, ZIP 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	•		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	however, it lacked associated notes of PRN lorazepam. Fensure PRN psych when needed or drisk of a resident of movements [tardivented or since and the phase ither box" to indicate they had just control obtained orders to they had just control obtained orders to they had just control obtained orders to the DON explained with medication moders to the phase ither box" to indicate the pollow up on the consince she started and was actively with medication moders are given and was actively with the pollow up on the consince she started and was actively with medication and without the policy outlined are made. A provided Medication and without the policy outlined duration and without the policy outlined drugs are limited to attending physicial believes that it is a second or the policy outlined and without the policy outlined duration and without the policy outlined drugs are limited to attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy outlined attending physicial believes that it is a second or the policy of the policy outlined attending physicial believes that it is a second or the policy of the pol	signed by the physician; any written direction or on how to address the identified RN-C stated it was important to notropic were provided only iscontinued timely to reduce the developing "abnormal		58			

NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOIDEN VALLEY CARE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE M225 ST CROIX AVENUE GOLDEN VALLEY, MIN 55422 (XA) ID SUMMARY STATEMENT OF DEFICIENCES BY FILL REGULATORY OR LOS DESTITYING INFORMATION) FREETY TAG TAG TAG PROVIDERS PLAN OF CORRECTION FREETY TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR STREET ADDRESS, CITY, STATE, ZIP CODE			245322	B. WING		0.5	
F 758 Continued From page 24 document their rationale in the resident's medical record and indicate the duration for the PRN	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	•	7 I ZI ZUZZ
document their rationale in the resident's medical record and indicate the duration for the PRN	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION
${}_{1}$	F 758	document their ration record and indicate	onale in the resident's medical	F 7	758		

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00183	B. WING		05/1	2/2022
	PROVIDER OR SUPPLIER	FN VALLEY CAR 5825 ST C	DRESS, CITY, S ROIX AVEN VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments ****ATTE	NTION*****	2 000			
	In accordance with 144A.10, this correct found that the defication are not corrected shall with a schedule of function the Minnesota Department of which corrected requires of the requirements of the matter of the requirements	nether a violation has been				
	comply with any of the lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item iring the initial inspection was				
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these ta written request is made to nin 15 days of receipt of a nt for non-compliance.				
	surveys were condustry surveyors from the Health (MDH). Your compliance with the following correction	Icensing and complaint acted at your facility by Minnesota Department of facility was found NOT in MN State Licensure and the orders are issued. Please stronic plan of correction you				

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

(X6) DATE TITLE

Electronically Signed

06/03/22

Minnesota Department of Health

	AND BLAN OF CORRECTION TO IDENTIFICATION NITIMBED:		` ´	X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00183	B. WING			C 12/2022	
		00100				IZIZUZZ	
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE			
COVENA	NT LIVING OF GOLD	FN VALLEY CAR	ST CROIX AVEN DEN VALLEY, M				
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO 1 DEFICIENCE		DATE	
2 000	Continued From pa	ge 1	2 000				
	have reviewed thes when they will be co	e orders and identify the da ompleted.	ate				
	The following comp UNSUBSTANTIATE H5322083C (MN80						
	H5322084C (MN82 H5322085C (MN82	(057)					
	•	nent of Health is documenti Correction Orders using	ng				
	federal software. Ta assigned to Minnes	ag numbers have been on the state statutes/rules for					
	appears in the far le	e assigned tag number eft column entitled "ID Prefi					
	listed in the "Summ	tute/rule out of compliance ary Statement of Deficiences the "To Comply" portion of the continuous	ies"				
	the correction order	r. This column also includes are in violation of the state					
	statute after the sta	tement, "This Rule is not mollowing the surveyors finding					
	are the Suggested Time period for Cor	Method of Correction and rection.					
	receipt of State lice	participate in the electronic					
	Informational Bullet	in	1:_				
	n/infobulletins/ib14_	state.mn.us/facilities/regula _1.html The State licensing ed on the attached Minneso					
	Department of Hea	Ith orders being submitted to Although no plan of correct	to				
	enter the word "cor	ate Statutes/Rules, please rected" in the box available	for				
	State licensure prod	indicate in the electronic cess, under the heading					
	· ·	e date your orders will be lectronically submitting to th	ne				

Minnesota Department of Health

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	PLE CONSTRUCTION IG:	COMP	LETED	
		00183	B. WING _		0 5/1) 2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CIT	/, STATE, ZIP CODE		
	NT LIVING OF GOLD	EN VALLEY CAR	ST CROIX AVE	NUE		
		GOLL	DEN VALLEY, M	T		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 2	2 000			
	Minnesota Departm	nent of Health.				
2 565	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL IS NO REQUIREM! CORRECTION FOI MINNESOTA STAT MN Rule 4658.0408 Plan of Care; Use Subp. 3. Use. A co	AN OF CORRECTION." THERE AL DEFICIENCIES ONLY IN IT IN	IIS Y. RE			6/3/22
	by: Based on interview facility failed to ensice completed as identified residents (R26) review. Findings include: R26's admission Mit 4/12/22, identified Findings include requirement and re	ent is not met as evidenced and document review, the ure weight monitoring was ified on the care plan for 1 driewed for weight loss. inimum Data Set (MDS), da R26 had severe cognitive quired extensive assistance of daily living (ADLs).	of 2 ated	Corrected		
	stated she felt she was work	5/9/22 at 3:42 p.m., R26 was getting enough food an king with speech therapy to wallowing. R26 voiced no				

Minnesota Department of Health

STATE FORM LWD911 If continuation sheet 3 of 22

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						;
		00183	B. WING		05/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
COVENA	NT LIVING OF GOLD	FN VALLEY CAR	CROIX AVEN VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	concerns with unpla gain.	anned weight loss or weight				
	4/29/22, identified respoke with R26's far concerned about R2 mass. The note out weight collected on 4/12/22 and the new exact same, at 269 questions accuracy show some fluctuate member] and reside lost a little muscle as much discuss recommend daily waccuracy. Both part	mpleted progress note, dated egistered dietitian (RD)-A mily member who was 26 losing weight and muscle dined there had been no R26 since admission on west weight entered was the lbs. The note identified, "RD of 4/26/22 as weights typically ion spoke w/ [with] [family ent. Resident stated I think I've and weight due to not moving ed w/ resident and daughter, reights to obtain weight ies agreed. Daily weights MD [medical doctor] notified of t."				
	identified R26 was a status and unintentified several goals "Weight to remain so no sig[nificant] wt [viseveral intervention]	eport, printed 5/12/22, at risk of impaired nutritional ional weight loss. The report for R26 which included, stable 271 # [lbs] +/- 3% with weight] changes," along with is to help R26 meet these AILY WEIGHT IN PLACE SHT ACCURACY."				
	printed 5/12/22, ide recorded weights in included the following	sident Vital Sign Report, ntified R26's collected and the medical record. This ng since the daily weights or recommended by the RD:				
	4/26/22 - 269.00 lbs 4/27/22 - "ADL Not 4/30/22 - "ADL Not	Scheduled."				

Minnesota Department of Health

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING: (X3) DATE		SURVEY		
		00183	B. WING		05/1) 2/2022
	PROVIDER OR SUPPLIER	EN VALLEY CAR 5825 ST C	DRESS, CITY, S CROIX AVENI VALLEY, MN		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	refusals, for the renon the report. Furth reviewed and lacked daily weights had be despite being requested to a series of the nursing assistant (Nappetite" and typical meals. NA-A stated daily weight, and excollected, recorded the nurse. NA-A additionally weight, and excollected, recorded the nurse. NA-A additionally weight, and excollected, recorded the nurse. NA-A additionally weight of the nursing home. When interviewed of the registered nurse unwas on a daily weight obtaining and recorded added she believed. "I don't know how containing and recorded the nursing home interviewed and the stated she was away weights had not be felt the nursing home improving the collection." When interviewed to stated R26 was weight loss" which is R26 and her family	cheduled." Scheduled." Inded weights, or documented hainder of the days not listed er, R26's medical record was do any further evidence these een obtained and documented ested and/or ordered by the Index of the these een obtained and documented ested and/or ordered by the Index of the these een obtained and documented ested and/or ordered by the Index of the these een obtained all her provided she was aware R26 was on a colained it was supposed to be in the computer, and given to ded she was unaware if R26 weight loss since she admitted ested to the				

Minnesota Department of Health

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00183	B. WING		05/1) 2/2022
NAME OF F	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 00/1	
NAIVIE OF F	ROVIDER OR SUPPLIER		ROIX AVEN			
COVENA	COVENANT LIVING OF GOLDEN VALLEY CAR GOLDEN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	started on 4/26/22 a weights] have not be Further, RD-A state getting enough nutrihave been complete. A facility policy on weights.	eight monitoring and/or				
	provided. SUGGESTED MET	HOD OF CORRECTION:				
	review and revise personal to ensuring the care resident is followed designee could develop a monitorial to ensuring the care resident is followed.	olicies and procedures related plan for each individual. The director of nursing or elop a system to educate staff itoring system to ensure staff as directed by the written plan				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			6/3/22
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as designed 4658.0405. A nursion of bed as much as written order from the custodial care, and individual needs and the comprehensive plan of care as designed as much as written order from the custodial care, and individual needs and individual needs and the custodial care, and individual needs and the custodial care as designed as a custodial care, and individual needs and the custodial care as designed as a custodial care, and individual needs and the custodial care as designed as a custodial care, and individual needs are custodial care, and individual needs are care as designed as a custodial care, and individual needs are custodial care, and	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00183	B. WING		05/1	; 2/2022
NAME OF BROWER OR OURDING		DDEGG OITY	OTATE 71D OODE	1 00/1	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COVENANT LIVING OF GOL	DEN VALLEY CAR	CROIX AVEN VALLEY, MI			
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		COMPLETE DATE
2 830 Continued From p	age 6	2 830			
This MN Requirer by: Based on observate review, the facility inserted central camonitored and chatandard of care the complication for 1 for intravenous (IN Findings include: A National Library article, peer-review as a long, thin tube the upper arm who near your heart." medications into the needed. A section Changes," identified reduce the risk of insertion site dry a change the dressing R26's admission In 4/12/22, identified impairment and rewith most activities the MDS identified medication while and of the section of the	nent is not met as evidenced tion, interview, and document failed to ensure a peripherally atheter (PICC) dressing was anged in accordance with the o reduce the risk of of 1 resident (R26) reviewed		Corrected		
	olored and the dressing was beeling around the perimeter;				

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		00183	B. WING		0 5/1	; 2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
COVENA	COVENANT LIVING OF GOLDEN VALLEY CAR 5825 ST GOLDEN					
			VALLEY, MN	PROVIDER'S PLAN OF CORRECTI	ON.	()/(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	along the bottom of "05/01/22 [eight day getting antibiotics the sure when it was go R26 stated she was were changing the insertion site but depotential infection (insertion). R26's Standing Ord Facilities, dated 1/6 labeled, "IV Line Material"	f paper tape was present the dressing which read, ys prior]." R26 stated she was arough the PICC and was not bing to be removed. Further, sunsure how often the staff clear dressing over the enied any symptoms of e.e., chills, fever, respiratory lers for Skilled Nursing /21, identified a section anagement," which directed, ne and site care per facility				
	included ceftriaxon of the long with a treatment of the long with a long with a rapid decline included completed "by shifts subsequent physicial identified R26's inference of the long with long long with a long long with a long long with a long long long long long long long long	der Sheet, dated May 2022, e (an antibiotic) 2 gram (gm) 42 days (starting 4/6/22), ent which read, "IV THERAPY nce, dressing, flushes, IV type, ication, temps," to be starting on 4/6/22. R26's an order, dated 5/10/22, ection had improved; however, e the IV antibiotics through ne PICC removed afterward. The reviewed physician orders ow often to change R26's PICC ure adequate protection of the risk of contamination or				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00183	B. WING		05/1	2/2022
	PROVIDER OR SUPPLIER	EN VALLEY CAR 5825 ST C	DRESS, CITY, S CROIX AVENU VALLEY, MN		•	
(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 APPROPERTION OF CORRECTION SHOULD DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	infection). The note found to have a DV her arm with the Ple emergency departs PICC placed due to R26's Care Plan Residentified R26 had a listed a goal of R26 of active infection. Interventions to help monitoring for antib worsening symptom personal protective However, the care pinterventions or car despite R26 receiving device since admission a month prior. During subsequent a.m., R26 continued present in her right clear dressing continued present along the powas now removed a blue-colored, illegible the tape had been personal protective. In the personal protective present along the powas now removed a blue-colored, illegible the tape had been personal protective. In the personal protective present along the personal protection, respectively. When interviewed descentible provided it recently. When interviewed descentible provided provi	e brain in the setting of identified on 4/8/22, R26 was T (deep vein thrombosis) in CC, so she was sent to the nent (ED) to have another or requiring ongoing antibiotics. Eport, printed 5/12/22, an active cranial infection and having no signs or symptoms. The care plan listed several por R26 meet this goal including iotic side effects, reporting instead to the physician, and equipment, if indicated. Plan lacked any recorded edirection for the PICC line ing IV medication through the sion to the nursing home over observation on 5/11/22 at 7:55 do to have the PICC line arm with a clear dressing. The inued to have slight peeling erimeter; however, the tape and the dressing had faint alle writing on the bottom where prior. Immediately following gistered nurse (RN)-B and R26's room to administer piotic. RN-B was questioned on ling and voiced she had not				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		00183	B. WING		0 5/1) 2/2022
	PROVIDER OR SUPPLIER	FN VALLEY CAR 5825 ST C	DRESS, CITY, S CROIX AVEN VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	physician order for tracked and docum the medical record; she was not sure if out for R26 in the property of R26's treatments at R26's PICC line dream that R26's PICC line dream with IV line changes, and she reinfection control and weeks prior; however follow-up or new dir RN-B again stated and documented in were no orders, the implement something tracked. R26's medical recorded and documented in were no orders, the implement something tracked. R26's medical recorded and documented in were no orders, the implement something tracked. R26's medical recorded and documented in were no orders, the implement something tracked. R26's medical recorded and documented in were no orders, the implement something tracked. R26's medical recorded in the ED. On 5/11/22 at 9:03 manager (RN)-C was physician orders. R home with the PICC receive IV antibiotic the dressing being date, it had likely be on the weekly basis stated all PICC line recorded in the medimportant to ensure important to ensure import	ge 9 erated they go by the specific each patient. This should be ented under the treatments in however, RN-B then voiced she ever recalled signing it ast weeks. RN-B reviewed and verified it lacked evidence essing had been changed. It is the had noticed there was poor care, including dressing aised the issue with the diprevention nurse a few er, had not received any rection since then. Further, the dressing should be ince with physicians' orders the medical record. If there in "the facility has to ing" to ensure it's changed and ard was reviewed and lacked lCC line dressing had been 2 when the new PICC was a.m. the registered nurse unit as interviewed and explained as should be changed every otherwise directed in the 26 admitted to the nursing a line in place and continued to should be changed every otherwise directed in the 26 admitted to the nursing a line in place and continued to should be. Further, RN-C dressing changes should be dical record and it was the dressing was actually recorded as "the risk of	2 830			

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00183	B. WING		05/1) 2/2022
	PROVIDER OR SUPPLIER	EN VALLEY CAR 5825 ST C	DRESS, CITY, S ROIX AVEN VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	infection control and (RN)-D stated the far PICC line dressing entered and records treatments of the mathematical record change would be a aside from the general RN-D stated it was dressing was change reduce the risk of innot recall any staff is concerns about IV is weeks. Further, RN provided to the nurs month prior and, again should be changed. A provided Central Changes policy, data transparent, semi-parent, semi-p	on 5/12/22 at 10:15 a.m. the diprevention registered nurse acility' policy was to change a "weekly" and should be ed in the physician orders and redical record. RN-D reviewed and stated the dressing separate order and treatment eral monitoring one listed. important to ensure the ged on a weekly basis to help rection and added she could reaching out to her with management in the past -D stated education was just sees during a skills fair the rain, verified the dressing weekly. Venous Catheter Dressing ted 4/2016, identified remeable membrane dressing the every 5 - 7 days and as and time of the dressing rescription of the insertion site, ons from the dressing change d in the medical record. on, interview, and document ailed to ensure physician and orders were clarified and the pain medication and r 1 of 2 residents (R297)	2 830			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			D WING		C	
		00183	B. WING		05/1	2/2022
	PROVIDER OR SUPPLIER	5825 ST (DRESS, CITY, S	STATE, ZIP CODE		
COVENA	COVENANT LIVING OF GOLDEN VALLEY CAR GOLDEN			55422		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG	`	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	R297 admitted to the of the nursing home hospital with an adr	printed 5/12/22, identified transitional care unit (TCU) in early May 2022 from the mission diagnosis of displaced cture of the right femur (leg				
	5/3/22, identified R2 admission to the number the care plan labeled R297 had actual pathe remainder of the	esident Care Plan, dated 297's initial care needs upon irsing home. The section of ed, "Pain Control," identified in her right leg. However, e section, including spaces to nt interventions, was left blank				
	wheelchair while in was extended outw waiting for a heat pair is terrible" in her rig fall prior to admission	.m., R297 was seated in her her room. R297's right leg ard and R297 stated she was ack from the staff as her "pain ht leg which stemmed from a on. R297 described the pain es" and voiced it extended er ankle and toes.				
	dated 5/9/22, identification physician assistant family' request. The poor pain control or acetaminophen ord R297's listed pain not including acetaminothree times a day a week period. The numbers age from [R2 concerned about he [R297] again today	Physicians SKILLED note, fied R297 was seen by the (PA) for her pain control at note identified R297 reported a 5/4/22, and her ers were changed as a result. nedications, as of 5/9/22, ophen 1000 milligrams (mg) and aspirin 81 mg daily for four ote included dictation, 97's family member] er pain control. Went to see and she reported her pain is ring in bed but much worse				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422 (24) ID PREFIX TAG Continued From page 12 when moving around Discussed with [R297's family member], and we decided some low dose oxycodone [a narcotic medication] would help her participate in therapies with less pain. Since she reported the pain is also bad in the middle of the night, will schedule a dose for bedtime." The note concluded with a section labeled, "Assessment and Plan," which outlined several new recommendations including oxycodone 2.5 mg twice a day (every moming and bedtime) for seven days then consider a reduction. However, R297's corresponding Twin Cities Physicians order sheet, dated 5/9/22, identified the (PA) orders from the 5/9/22 visit. These included: 1) Lidocaine 4% patches to be applied to R297's right hip for 12 hours, then removed for 12 hours; 2) Diclofenac topical gel 1% (an anti-inflammatory medication) applied to the right hip four times a day; and, 3) Apply ice to the right hip in 20 minute increments four time a day for three days. The completed physician orders did not include any orders for oxycodone despite being listed in the plan of the corresponding progress note by	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING:		` '	COMPLETED	
COVENANT LIVING OF GOLDEN VALLEY CAR SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG			00183		B. WING		05/	
(X4)ID (X4)ID (EACH DETECTION MALLEY CAR (SOLDEN VALLEY, MN 55422 (X4)ID (X4)ID (EACH DETECTION MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 12 (Participate in the rapies with less pain. Since she reported the pain is also bad in the middle of the night, will schedule a dose for bedtime. The note concluded with a section labeled, "Assessment and Plan," which outlined several new recommendations including oxycodone 2.5 mg twice a day (every morning and bedtime) for seven days then consider a reduction. However, R297's corresponding Twin Cities Physicians order sheet, dated 5/9/22, identified the (PA) orders from the 5/9/22 visit. These included: 1) Lidocaine 4% patches to be applied to R297's right hip for 12 hours, then removed for 12 hours; 2) Diclofenac topical gel 1% (an anti-inflammatory medication) applied to the right hip four times a day; and, 3) Apply ice to the right hip in 20 minute increments four time a day for three days. The completed physician orders did not include any orders for oxycodone despite being listed in	NAME OF	PROVIDER OR SUPPLIER	STRE	EET ADD	RESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 12 when moving around Discussed with [R297's family member], and we decided some low dose oxycodone [a narcotic medication] would help her participate in therapies with less pain. Since she reported the pain is also bad in the middle of the night, will schedule a dose for bedtime." The note concluded with a section labeled, "Assessment and Plan," which outlined several new recommendations including oxycodone 2.5 mg twice a day (every morning and bedtime) for seven days then consider a reduction. However, R297's corresponding Twin Cities Physicians order sheet, dated 5/9/22, identified the (PA) orders from the 5/9/22 visit. These included: 1) Lidocaine 4% patches to be applied to R297's right hip for 12 hours, then removed for 12 hours; 2) Diclofenac topical gel 1% (an anti-inflammatory medication) applied to the right hip four times a day; and, 3) Apply ice to the right hip in 20 minute increments four time a day for three days. The completed physician orders did not include any orders for oxycodone despite being listed in	COVENANT LIVING OF GOLDEN VALLEY CAR							
when moving around Discussed with [R297's family member], and we decided some low dose oxycodone [a narcotic medication] would help her participate in therapies with less pain. Since she reported the pain is also bad in the middle of the night, will schedule a dose for bedtime." The note concluded with a section labeled, "Assessment and Plan," which outlined several new recommendations including oxycodone 2.5 mg twice a day (every morning and bedtime) for seven days then consider a reduction. However, R297's corresponding Twin Cities Physicians order sheet, dated 5/9/22, identified the (PA) orders from the 5/9/22 visit. These included: 1) Lidocaine 4% patches to be applied to R297's right hip for 12 hours, then removed for 12 hours; 2) Diclofenac topical gel 1% (an anti-inflammatory medication) applied to the right hip four times a day; and, 3) Apply ice to the right hip in 20 minute increments four time a day for three days. The completed physician orders did not include any orders for oxycodone despite being listed in	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
the PA, and despite having been reviewed and discussed with R297's family member to help R297 have better pain control and potentially participate better with therapies. The orders were dated with a handwritten 5/9/22 by the nursing home staff. R297's subsequent Resident Vital Sign Report (for pain), dated 5/10/22 to 5/11/22, identified R297 rated her pain between a 1.0 and 2.0 (on a	2 830	when moving arour family member], an oxycodone [a narco participate in therapreported the pain is night, will schedule concluded with a seand Plan," which our recommendations it wice a day (every reven days then concluded: 1) Lidocaine 4% paright hip for 12 hour 2) Diclofenac topical medication) applied day; and, 2) Diclofenac topical medication) applied day; and, 3) Apply ice to the reincrements four time. The completed phy any orders for oxycothe plan of the correct the PA, and despited discussed with R29 R297 have better participate better with dated with a handwith home staff. R297's subsequent (for pain), dated 5/1	and Discussed with [R297] d we decided some low do to the medication] would help bies with less pain. Since so also bad in the middle of a dose for bedtime." The rection labeled, "Assessment with a several new including oxycodone 2.5 mmorning and bedtime) for the section. The properties of the section of the section of the section. The properties of the section of the section of the section. The properties of the section of the se	lose pher she the note ng ed 97's ours; natory s a ort	2 830			

Minnesota Department of Health

STATE FORM LWD911 If continuation sheet 13 of 22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` '	E SURVEY PLETED	
		00183	B. WING			C 12/2022
	F PROVIDER OR SUPPLIER	FN VALLEY CAR 5825 ST C	DRESS, CITY, ST ROIX AVENU VALLEY, MN	JE		
(X4) IC PREFI TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 83	During subsequent p.m. R297 was lying R297's eyes were comfortable with no signs or symptoms. When interviewed or registered nurse (R to care for R297 and the nursing home was "pain patch" and RN-A stated there woxycodone. RN-A roote, and corresponstated the oxycodo being listed on the address R297's painthe process in place completed physicial unaware who, if any the physician progrous "never had the charstated he was unaware who, if any the physician progrous "never had the charstated he was unaware who, if any the physician progrous "never had the corresponding order to ensure the corresponding order to remove "confusing "actual plan" was befor the resident. When interviewed or registered nurse unphysician orders we coordinator (HUC) electronic medical there was poor confusion.	10" being the worst rating). observation on 5/10/22 at 2:11 g in bed while in her room. closed and she appeared obvious grimacing or physical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00183	B. WING		05/1	2/2022
	PROVIDER OR SUPPLIER	FN VALLEY CAR 5825 ST C	DRESS, CITY, S CROIX AVENU VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	seen. RN-C explain assigned or directed incoming physician questions or needer and she expressed example of why the communication with and nursing staff. Filimportant to ensure and orders were classiful care to the patient and potential error whad the surveyor not and investigated the dictated the progress discussion with R29 the order for the oximich caused it to represent the caused it to represent the processiful care to the proces	ver told" of who was being led there was no staff d, to her knowledge, to review progress notes to ensure any d clarifications are obtained, this served as another y needed to improve in the medical provider group urther, RN-C stated it was conflicting or unclear notes arified to provide "continuity of and voiced this inconsistency would not have been identified of brought it to their attention. So a.m. the interim director of interviewed and stated she issue. The PA rounded and is note after having a part of the incorrect inbox not be received by the nursing and she discussed the and neither of them believed as a result of the incident; anted to still start the ded and would review R297 in the adequate pain control was and the pain control was and present and note scanning cord personnel and "moving going to begin looking at a rinconsistencies. The DON start to ensure physician the reviewed timely and for ensure orders weren't the pain management and/or diffication was requested and				

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Timmedeta Bepartment et me	aith		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00183	B. WING	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COVENA	ANT LIVING OF GOLDEN VALLEY CAR	ROIX AVEN VALLEY, MN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies for pain management, physician order process, and PICC line care; then educate direct care staff and conduct audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		6/3/22

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	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			D VAUNIO		c	
		00183	B. WING	_	05/1	2/2022
	PROVIDER OR SUPPLIER	5825 ST (DRESS, CITY, S	STATE, ZIP CODE UE		
COVENA	ANT LIVING OF GOLD	FN VALLEY CAR	VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 16	21540			
21540	This MN Requirements: Based on interview facility failed to ensity psychoactive medic of use or re-evaluate ensure necessity arromplication for 1 of for unnecessary medication and post (PTSD). Further, Raimpairment, demond (including rejection required extensive a of daily living (ADLs R26's Physician Ordincluded buspirone milligrams (mg) twice and lorazepam (and lorazepam (and lorazepam (and lorazepam) twice and a listed start daily living (ADLs R26's Care Plan Registed R26's Care Plan R26's C	and document review, the ure as-needed (PRN) cations were limited to 14 days ed by the medical provider to not reduce the risk of 5 residents (R26) reviewed edication use. Inimum Data Set (MDS), dated		Corrected		
	•	R26 meet this goal including monitoring for side effects of				

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AND DIANIOE CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00183	B. WING		05/1	2/2022
	PROVIDER OR SUPPLIER	FN VALLEY CAR 5825 ST C	DRESS, CITY, S CROIX AVENI VALLEY, MIN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	4/2022, identified R for the month as sig staff. This identified which identified it w 4/29/22 with the result of the stanking symptoms of addition, R26's May dated 5/2022, identified active order for the had received no do far. However, both recorded or directed medication. R26's Interim Medical A/6/22, identified the reviewed R26's physeveral recommence of the following medical recompleted report with mursing home staff. However, R26's meand lacked any recompleted report with nursing home staff. However, R26's meand lacked any recompleted report with nursing home staff. However, R26's meand lacked any recompleted report with nursing home staff. However, R26's meand lacked any recompleted report with nursing home staff. However, R26's meand lacked any recompleted report with nursing home staff. However, R26's meand lacked any recompleted report with nursing home staff. However, R26's meand lacked any recompleted report with nursing home staff.	edications report, dated 26's consumed medications and out by the nursing home R26's lorazepam PRN order as administered once on alts being recorded, "Pain = tered." There was no recorded or resolution on the report. In 2022 Medications report, ified R26 continued to have an PRN lorazepam, however, ses in the month period thus of these reports lacked any distops date for the PRN cation Regimen Review, dated e consulting pharmacist had escician orders and made dations including, "PRN is needs a 14 day stop date. evaluate continued need for ation(s): Lorazepam." The as signed on 4/22/22 by				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CAR SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	
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21540 Continued From page 18 21540	
registered nurse (RN)-B stated R26 did not display any anxiety or behavioral symptoms and described her as "pretty calm and pleasant." RN-B reviewed R26's current medication orders in the electronic record and verified R26 continued to have PRN lorazepam ordered and available for administration. RN-B stated she was unsure when, or if, a stop date was determined for the medication. RN-B explained she was aware most PRN psychotropic's needed to be stopped or have new orders written after 14 days; however, she did not know "the protocol" for how lorazepam specifically was addressed. RN-B added, "I didn't even know she was on Ativan [lorazepam] to be honest." When interviewed on 5/12/22 at 9:46 a.m.	
registered nurse unit manager (RN)-C stated she had reviewed R26's medical record, and she acknowledged there was no stop date identified for the PRN lorazepam nor was there evidence it's use had been re-evaluated by the medical provider. As a result, RN-C stated they "have a message out to the provider" for it to be addressed. RN-C reviewed the completed medication regimen review, dated 4/6/22, and explained those reports were forwarded to the nurse managers to be addressed. R26's report was reviewed and signed by the physician; however, it lacked any written direction or associated notes on how to address the identified PRN lorazepam. RN-C stated it was important to ensure PRN psychotropic were provided only when needed or discontinued timely to reduce the risk of a resident developing "abnormal movements [tardive dyskinesia]." On 5/12/22 at 10:48 a.m. the interim director of nursing (DON) was interviewed. The DON explained the pharmacy recommendation was	

Minnesota Department of Health

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NT LIVING OF GOLD	EN VALLEY CAR				
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signed by the physical not addressed as the either box" to indicate they had just contact obtained orders to of the DON explained with medication may follow up on the consince she started wand was actively we pharmacist to get the DON stated the PR been addressed with discontinued and explained and explained and explained. A provided Medicate 1/2022, identified an included any medic duration and without The policy outlined, drugs are limited to attending physician believes that it is applied be extended beyond document their rational record and indicate order." SUGGESTED MET The director of nurs review applicable popsychotropic medicand audit records to the standard audit records to th	cian, however, the issue was he physician "never checked ate a response. As a result, cted the physician and discontinue the medication. If she had noticed some issues nagement, including timely insulting pharmacist reviews, orking at the nursing home orking with the consulting nem resolved. However, the N lorazepam should have the medical provider or explained they "have to lean ers" to ensure orders or when the recommendations ion Management policy, dated in unnecessary medication ation used for excessive at adequate indication for use. "PRN orders for psychotropic 14 days. Exception: If the or prescribing practitioner oppopriate for the PRN order to de 14 days, he or she should onale in the resident's medical the duration for the PRN. THOD OF CORRECTION: THO OF CORRECTION: THE OF THE				
(21) days.					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT) Continued From pa signed by the physical not addressed as the either box" to indicate obtained orders to the DON explained with medication mand follow up on the consince she started we and was actively we pharmacist to get the DON stated the PR been addressed with discontinued and explained a	OF CORRECTION O0183 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 signed by the physician, however, the issue was not addressed as the physician "never checked either box" to indicate a response. As a result, they had just contacted the physician and obtained orders to discontinue the medication. The DON explained she had noticed some issues with medication management, including timely follow up on the consulting pharmacist reviews, since she started working at the nursing home and was actively working with the consulting pharmacist to get them resolved. However, the DON stated the PRN lorazepam should have been addressed with the medical provider or discontinued and explained they "have to lean back on our providers" to ensure orders or directions are given when the recommendations are made. A provided Medication Management policy, dated 1/2022, identified an unnecessary medication included any medication used for excessive duration and without adequate indication for use. The policy outlined, "PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies for as-needed psychotropic medication use; then educate staff and audit records to ensure ongoing compliance.	OPENOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Signed by the physician, however, the issue was not addressed as the physician "never checked either box" to indicate a response. As a result, they had just contacted the physician and obtained orders to discontinue the medication. The DON explained she had noticed some issues with medication management, including timely follow up on the consulting pharmacist reviews, since she started working at the nursing home and was actively working with the consulting pharmacist to get them resolved. However, the DON stated the PRN lorazepam should have been addressed with the medical provider or discontinued and explained they "have to lean back on our providers" to ensure orders or directions are given when the recommendations are made. A provided Medication Management policy, dated 1/2022, identified an unnecessary medication included any medication used for excessive duration and without adequate indication for use. The policy outlined, "PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies for as-needed psychotropic medication use; then educate staff and audit records to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	OF CORRECTION DOI 183 B. WING	OPTION OF CORRECTION ON MANUAL PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE. ZIP CODE SEZS ST CROIX AVENUE GOLDEN VALLEY CAR GOLDEN VALLEY, MN 55422 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL PROVIDER OR SUPPLIER OF CORRECTION OF CORRECTION OR SEZES ST CROIX AVENUE GOLDEN VALLEY, MN 55422 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL PROVIDER OR SEZES ST CROIX AVENUE GOLDEN OF CORRECTION OR SEZES ST CROIX AVENUE GOLDEN OR SEZES ST CROIX AVENUE OF PRETIX OR SEZES ST CROIX AVENUE OF PROVIDERS PLAN OF CORRECTION OR SEZES ST CROIX AVENUE OF PRETIX OR SEZES ST CROIX AVENUE OF PRETIX OR SEZES ST CROIX AVENUE OF PRETIX OR SEZES ST CROIX AVENUE OF PROVIDERS PLAN OF CORRECTION OR SEZES ST CROIX AVENUE OF PROVIDERS PLAN OF CORRECTION OR SEZES ST CROIX AVENUE OF PROVIDERS PLAN OF CORRECTION OR SEZES ST CROIX AVENUE OF PROVIDERS PLAN OF SEZES ST CROIX AVENUE OF PROVIDERS PLAN OF CORRECTION OR SEZES ST CROIX AVENUE OF PROVIDERS OF PROVIDERS OF PROVIDERS OF PRETIX OR SEZES ST CROIX AVENUE OF PROVIDERS OF PROVIDERS OF PROVIDERS OF PRETIX OR SEZES ST CROIX AVENUE OF PROVIDERS

Minnesota Department of Health

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Minnesota Department of Health

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21942	MN St. Statute 144A Resident and Famil	4.10 Subd. 8b Establish y Councils	21942			6/3/22
	boarding care home advisory council and fewer than three per participating. If one function, the nursing home shall docume council or councils a year. This subdivision	council. Each nursing home or e shall establish a resident d a family council, unless rsons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of es provided by section n 27.				
	by: Based on interview facility failed to attend council during the pathe potential to affect facility.	ent is not met as evidenced and document review, the mpt to establish a family ast calendar year. This had ct all 57 residents in the		Corrected		
		y document Family Council ne date was 10/22/19.				
	During an interview social worker (SW)	on 5/10/22, at 2:40 p.m. the stated there was no attempt uncil during COVID-19. SW				
	•	on 5/10/22, at 3:30 p.m. the I the last time there was a on 10/22/19.				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF GOLDEN VALLEY CAR (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) NOT THE APPROPRIATE DEFICIENCY) (21942 Continued From page 21 NAME OF PROVIDER OR SUPPLIER	,
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21942 Continued From page 21 21942	ETE
Although a family council policy was requested, none was provided.	
SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review facility systems for family council and work on promotion and encouragement of this group on an annual basis.	
TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	

F5322032

PRINTED: 06/22/2022 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CORRECTION INTERPRETATION AND BLANCE AT THE CATION AND IMPERIT		\	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	` '	(X3) DATE SURVEY COMPLETED	
		245322	B. WING _		05/	10/2022
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K 000	INITIAL COMMENT	S	K 0	00		
	FIRE SAFETY					
	conducted by the M Public Safety, State 05/10/2022. At the Living Of Golden Va was found not in co requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) 101, Life Sa	eticipation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 e and the 2012 edition of				
	ALLEGATION OF CONTROL	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT OF A CONDUCTED TO A SUBSTANTIAL CORREGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.				
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY				
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D.				
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURF	TITLE		(X6) DATE

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

(X6) DATE

Electronically Signed

06/03/2022

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	COMPLETED		
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K 000	Continued From pa	age 1	K 00	00		
	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145				
	By email to: FM.HC.Inspections	@state.mn.us				
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
		cription of the corrective action correct the deficiency.				
		easures that will be put in deficiency does not reoccur.				
		ne facility plans to monitor e to ensure solutions are				
	_	responsible for the corrective ring of compliance.				
	5. The actual or posture the remedy.	proposed date for completion of				
	building with no base and was determine construction. Addition 1976, and 1998 and Type II(000) construction, State Licensed only because they are nated construction,	Golden Valley is a 1-story sement that was built in 1960 ed to be of Type II(000) ions were built in 1963, 1970, d were all determined to be of auction. This building houses y beds that are private pay, but not separated by 2-hour fire that portion will be included in cility shares a common wall				

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
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K 345	separated by 2-hou facility is fully proted automatic fire sprin alarm system with a corridors and space centrally monitored notification. The facility has a cacensus of 59 at the The requirements a are NOT MET as exprised fire Alarm System CFR(s): NFPA 101 Fire Alarm System A fire alarm system accordance with an with the requirement Electric Code, and and Signaling Code acceptance, mainted available. 9.6.1.3, 9.6.1.5, NFThis REQUIREMENT by: Based on a review and staff interview, fire alarm system put a larm system system system put a larm system	r rated construction. This cted throughout by an kler system and has a fire smoke detection in the es open to the corridors that is for automatic fire department apacity of 88 beds and had a time of the survey. At 42 CFR, Subpart 483.70(a), widenced by: Testing and Maintenance Testing and Maintenance is tested and maintained in approved program complying approved program complying approved of System enance and testing are readily PA 70, NFPA 72 NT is not met as evidenced of available documentation the facility failed to inspect the er NFPA 101 (2012 edition), ection 9.6.1.5, and NFPA 72 National Fire Alarm and ction 14.3.1. This deficient a widespread impact on the	K 345		nits on of d plan oliance eged
	amgo molado.			Solidion of Fioles of Grand to Gab	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING 01 - MAIN BUILDING 01	
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K 345	it was revealed by documentation that completing semiar. An interview with F	ween 09:00 AM and 12:00 PM, a review of available the facility had not been mual fire alarm inspections. Regional Director of Facilities ed this deficient finding at the	K 34	at the request of the Minnesota Department of Public Health. Prepand execution of this response an of correction does not constitute a admission or agreement by the prethe truth of the facts alleged or conclusions set forth in the statem deficiencies. 1. A detailed description of the correct deficiency a. The facility has completed Annualarm inspections using Johnson Controls, a life safety equipment contractor. The Annual fire inspection mass added to facilities Life Safety Inspection Calon 6/2/22. The Semiannual fire alarm inspection was added to facilities Life Safety Inspection Calon 6/2/22. The Semiannual fire alainspection will be scheduled within months from the completion of the fire inspection of 2/16/2022. 2. Address the measures that will in place to ensure the deficiency director. 3. Indicate how the facility plans to monitor future performance to ensure the scheduled a. The Semiannual fire inspection been added to the facilities Life Salnspection Calendar that is monitor regularly. The FMD/designee will regularly. The FMD/designee will regularly. The FMD/designee will regularly. The FMD/designee will regularly.	d plan n ovider of ent of ent of rective the tal fire tion was nual the lendar arm asix (6) Annual be put oes not ection nths fire ure has afety ared

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	Subdivision of Build CFR(s): NFPA 101 Subdivision of Build Construction 2012 EXISTING Smoke barriers shafire resistance rating be permitted to term Smoke dampers are penetrations in fully an approved sprink smoke compartments barrier. 19.3.7.3, 8.6.7.1(1)	ling Spaces - Smoke Barrie ling Spaces - Smoke Barrier all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall ninate at an atrium wall. e not required in duct ducted HVAC systems where ler system is installed for nts adjacent to the smoke	K 34	the results of the Semiannual fire a inspection to the QAPI committee. 4. Identify who is responsible for the corrective actions and monitoring of compliance a. The Director of Facilities Manage or designee will be responsible to responsible to responsible to responsible to the Life Safety Inspection Calendar ensuring that the Semiannual fire a inspection will be scheduled within months from the completion of the fire inspection, results will be report QAPI committee. 5. Completion date a. Thursday, June 2nd, 2022.	e of ement eview ralarm six (6) Annual	
	This REQUIREMENtly: by: Based on observat	NT is not met as evidenced ion and staff interview, the ntain their smoke barrier per		K372 – A Penetration in The Smok Barrier Caused By An Electrical Co		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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K 372	sections 19.3.7.1, 1 This deficient finding impact on the resident findings include: On 05/10/2022 between the selectrical conduit al 156. An interview with the selectron in the selectron conduit al 156.	dition), Life Safety Code, 19.3.7.3, 8.5.2.2, and 8.5.6.2. Ing could have a patterned lents within the facility. Ween 09:00 AM and 12:00 PM, observation that there was a smoke barrier caused by bove the ceiling near Room her verified this deficient	K 37	Above The Ceiling Near Room 156 Covenant Living of Golden Valley (and Rehabilitation respectfully sub this plan of correction as its allegat compliance. The following combine of correction and allegation of comis not an admission to any of the adeficiencies or violations and is sufat the request of the Minnesota Department of Public Health. Prepand execution of this response and of correction does not constitute an admission or agreement by the prothe truth of the facts alleged or conclusions set forth in the statem deficiencies. 1. A detailed description of the concidency and the smoke barrier can by an electrical conduit above the enear room 156. The Director of Famonagement review the site with the General Contractor on Thursday, and The General Contra	Care mits ion of ed plan pliance leged britted aration of ent of ent of ent of ent of eling cilities he lune 2. In the ent of en	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB CTE	₹	58	REET ADDRESS, CITY, STATE, ZIP CODE 25 ST CROIX AVENUE OLDEN VALLEY, MN 55422		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
K 923	Gas Equipment - Ct	ylinder and Container Storag	K 3		in the facility by contractors. 3. Indicate how the facility plans to monitor future performance to ensur solutions are sustained a. This inspection is on the Life Sa Inspection Calendar. Electricians an voltage contractors will be supervise Facility Maintenance Staff to ensure penetrations are appropriately Fire stopped. 4. Identify who is responsible for the corrective actions and monitoring of compliance a. The Director of Facilities Managor designee will be responsible to rethe Life Safety Inspection Calendar ensuring that the Annual inspection smoke barriers above the ceiling gric completed. 5. Completion date a. The General Contractor has agric appropriately Fire stop the penetration later than Friday, June 10.	re Ifety Id low Ied by Ithat Iement Iview of the Id is Ireed to Ion no	
	Gas Equipment - Cy Greater than or equi Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cu Storage locations a within an enclosed i limited- combustible gates outdoors) that gases are not store	ylinder and Container Storage al to 3,000 cubic feet re designed, constructed, and ance with 5.1.3.3.2 and bic feet re outdoors in an enclosure or interior space of non- or e construction, with door (or t can be secured. Oxidizing d with flammables, and are abustibles by 20 feet (5 feet if					

AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245322	B. WING _		05/10/2022	
	PROVIDER OR SUPPLIER	DEN VALLEY CARE & REHAB CTI	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422		
(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 SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE COMPLETION	
K 923	noncombustible co 1/2 hr. fire protection Less than or equal In a single smoke of cylinders available care areas with an or equal to 300 cuts stored in an enclose handled with precata A precautionary signer each door or gate of where the sign includers are cylinders and they are resulted to store of which they are resulted to avoid in the open are professing the considered empty are marked to avoid in the open are professing to store the signer of the considered empty are marked to avoid in the open are professing to store the considered empty are marked to avoid in the open are professing the considered empty are marked to store the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty are marked to avoid in the open are professing the considered empty	closed in a cabinet of construction having a minimum on rating. Ito 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than bic feet are not required to be sure. Cylinders must be autions as specified in 11.6.2. In readable from 5 feet is on of a cylinder storage room, udes the wording as a DN: OXIDIZING GAS(ES) NO SMOKING." I so cylinders are used in order eceived from the supplier. It is esgregated from full acility employs cylinders with auge, a threshold pressure is established. Empty cylinders and confusion. Cylinders stored of tected from weather. It is not met as evidenced attion and staff interview, the re oxygen cylinders per NFPA Health Care Facilities Code, and 11.6.5.3. This deficient an isolated impact on the effacility.	K 92	K923 - Gas Equipment - Cylinder Container Storage Covenant Living of Golden Valley of and Rehabilitation respectfully subthis plan of correction as its allegation compliance. The following combin of correction and allegation of comis not an admission to any of the adeficiencies or violations and is suat the request of the Minnesota Department of Public Health. Prep	Care mits tion of ed plan pliance lleged bmitted	
	it was revealed by storage room had	•		at the request of the Minnesota	aration d plan	

	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			. ,	(X3) DATE SURVEY COMPLETED	
		245322	B. WING		05/	10/2022
	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB C	TR	STREET ADDRESS, CITY, STATE, ZIP C 5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE
K 923		d. ne Regional Director of nent verified this deficient	K 9	admission or agreement by the truth of the facts alleged conclusions set forth in the set deficiencies. 1. A detailed description of action taken or planned to deficiency a. Corrective action was thempty oxygen cylinders have separated and signage was posted. b. Facilities maintenance have with the building architect recoxygen room storage and etc. 2. Address the measures in place to ensure the deficing reoccur a. Facilities staff removed equipment from the room. Of were placed in holders and Facility has consulted with reproviders to update equipmed. Indicate how the facility monitor future performance solutions are sustained a. The Director of Nursing will audit the oxygen room fing week for three months. b. The Director of Nursing completed education with the and the Housekeeping Supplement for separating full and tanks Completion date: 6-4. Identify who is responsi corrective actions and monit compliance a. The Director of Nursing Director of Facilities Manage b. Audits will be reviewed	I or statement of the correct the correct the nat the full and re been created and has consulted egarding xpansion that will be put ency does not excessive Dxygen tanks separated espiratory ent needs plans to to ensure or designee ive times a or	

	MENT OF DEFICIENCIES AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED					
		245322	B. WING			05/	10/2022	
	PROVIDER OR SUPPLIER	EN VALLEY CARE & REHAB CT	R	58	TREET ADDRESS, CITY, STATE, ZIP CODE 825 ST CROIX AVENUE 6OLDEN VALLEY, MN 55422	<u> </u>		
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I	Continued From pa	ge 9	KS	923	Committee to identify trends, make recommendations, and ensure ong compliance 5. Completion date: Friday, June 2022	oing		