

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LWM9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245184 2.STATE VENDOR OR MEDICAID NO. (L2) 690925600	3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - ROCHESTER EAST (L4) 501 EIGHTH AVENUE SOUTHEAST (L5) ROCHESTER, MN (L6) 55904	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 3. Termination 5. Validation 7. On-Site Visit 2. Recertification 4. CHOW 6. Complaint 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 05/12/2006 6. DATE OF SURVEY 04/16/2012 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP 09 ESRD 10 NF 11 IMR 12 RHC 13 PTIP 14 CORF 15 ASC 16 HOSPICE 22 CLIA	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 116 (L18) 13.Total Certified Beds 116 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>1.</u> Acceptable POC 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF (L37) 18/19 SNF 116 (L38) 19 SNF (L39) ICF (L42) IMR (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks		
17. SURVEYOR SIGNATURE <u>Robin Lewis, HFE NEII</u>	Date : 05/01/2012 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Mark Meath, Program Specialist</u>
		Date: 05/21/2012 (L20)

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate _____ 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT: _____	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____
22. ORIGINAL DATE OF PARTICIPATION 09/01/1972 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)	
26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS DETERMINATION APPROVAL
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 04/17/2012 (L33)	

C&T REMARKS - CMS 1539 FORM

On April 16, 2012, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the March 1, 2012 standard survey, effective April 10, 2012. Refer to the CMS 2567b for health.

Effective April 10, 2012, the facility is certified for 116 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5184

May 21, 2012

Ms. Carey Huebert, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Dear Ms. Huebert:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program

Effective April 10, 2012 the above facility is certified for:

116 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 116 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

May 1, 2012

Ms. Carey Huebert, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

RE: Project Number S5184024

Dear Ms. Huebert:

On March 21, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On April 16, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 1, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2012, effective April 10, 2012 and therefore remedies outlined in our letter to you dated March 21, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, reading "Gary Nederhoff", is positioned above the typed name and title.

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

5184r12.rtf

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245184	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/16/2012
Name of Facility GOLDEN LIVINGCENTER - ROCHESTER EAST		Street Address, City, State, Zip Code 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0276</u> Reg. # <u>483.20(c)</u> LSC _____	Correction Completed 04/10/2012	ID Prefix <u>F0279</u> Reg. # <u>483.20(d), 483.20(k)(1)</u> LSC _____	Correction Completed 04/10/2012	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 04/10/2012
ID Prefix <u>F0318</u> Reg. # <u>483.25(e)(2)</u> LSC _____	Correction Completed 04/10/2012	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 04/10/2012	ID Prefix <u>F0329</u> Reg. # <u>483.25(l)</u> LSC _____	Correction Completed 04/10/2012
ID Prefix <u>F0412</u> Reg. # <u>483.55(b)</u> LSC _____	Correction Completed 04/10/2012	ID Prefix <u>F0428</u> Reg. # <u>483.60(c)</u> LSC _____	Correction Completed 04/10/2012	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed 04/10/2012
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ MM/GPN	Date: _____ 05/01/2012	Signature of Surveyor: _____ 30238	Date: _____ 04/16/2012		
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____		
Followup to Survey Completed on: 3/1/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					



Protecting, Maintaining and Improving the Health of Minnesotans

May 1, 2012

Ms. Carey Huebert, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Enclosed Reinspection Results - Project Number S5184024

Dear Ms. Huebert:

On April 16, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 1, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

A handwritten signature in black ink, reading "Gary Nederhoff".

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206/2731 Fax: (507) 206-2711

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5184r12lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00953	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/16/2012
Name of Facility GOLDEN LIVINGCENTER - ROCHESTER EAST		Street Address, City, State, Zip Code 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>20550</u> Reg. # <u>MN Rule 4658.0400 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012	ID Prefix <u>20560</u> Reg. # <u>MN Rule 4658.0405 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012	ID Prefix <u>20830</u> Reg. # <u>MN Rule 4658.0520 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012
ID Prefix <u>20895</u> Reg. # <u>MN Rule 4658.0525 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012	ID Prefix <u>21325</u> Reg. # <u>MN Rule 4658.0725 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012	ID Prefix <u>21375</u> Reg. # <u>MN Rule 4658.0800 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012
ID Prefix <u>21530</u> Reg. # <u>MN Rule 4658.1310 A.B.C</u> LSC <u> </u>	Correction Completed 04/16/2012	ID Prefix <u>21535</u> Reg. # <u>MN Rule 4658.1315 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012	ID Prefix <u>21942</u> Reg. # <u>MN St. Statute 144A.10 Subp. 1</u> LSC <u> </u>	Correction Completed 04/16/2012
ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed	ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed	ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed
ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed	ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed	ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed

Reviewed By <u> </u> State Agency	Reviewed By <u> </u> MM/GPN	Date: 05/01/2012	Signature of Surveyor: 30238	Date: 05/01/2012
Reviewed By <u> </u> CMS RO	Reviewed By <u> </u>	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/1/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



Protecting, Maintaining and Improving the Health of Minnesotans

Sent Federal Express Overnight - March 29, 2012

March 29, 2012

Ms. Carey Huebert, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Dear Ms. Huebert:

Recently you received a CMS form 2567 and State form pursuant to a standard survey completed on March 1, 2012 by the Departments of Health and Public Safety. Since sending the original forms, changes have been made to the health deficiencies and orders. Enclosed you will find the revised health forms.

If you have questions about the revised health forms (CMS-2567, State Forms), please contact:

Gary Nederhoff, Supervisor
Rochester District Office
Licensing and Certification Program
Minnesota Department of Health
18 Wood Lake Drive, Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

We apologize for any inconvenience this may have caused.

If you have additional questions, please don't hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0970
Telephone: (651) 201-4212 Fax: (651) 281-9796

Enclosure



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7152

March 21, 2012

Ms. Carey Huebert, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

RE: Project Number S5184024

Dear Ms. Huebert:

On March 1, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 10, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

5184s12.rtf



Protecting, Maintaining and Improving the Health of Minnesotans

Informal Dispute Requested

**This facility has requested an Informal Dispute
on the tag(s) identified below.**

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Golden LivingCenter Rochester East 00953	3/1/12	F323-E

Larson, Monica (MDH)

From: Absolon, Mary (MDH)
Sent: Thursday, April 05, 2012 9:01 AM
To: Larson, Monica (MDH)
Cc: Kerssen, Pam (MDH); Moen, Carol (MDH)
Subject: RE: IDR assignment request

fine

From: Larson, Monica (MDH)
Sent: Thursday, April 05, 2012 8:47 AM
To: Absolon, Mary (MDH)
Subject: IDR assignment request
Importance: High

Hi Mary,
I would like to assign Pat Halverson she is next in line.

PROVIDER - 00953, GOLDEN LIVINGCENTER ROCH EAST

IDR Type - IDR

Tags: FF323
Survey Date(Exit Date): 3-1-12

Review will be conducted - By telephone

Dates when facility cannot participate: June 4-8

Will attorney for facility be attending: No

No of persons attending: 4
Submitter Name: Carey Huebert
Email:carey.huebert@goldenliving.com

Monica Larson
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4113
Fax: (651) 215-9697

Monica.Larson@state.mn.us



Protecting, Maintaining and Improving the Health of Minnesotans

April 5, 2012

Ms. Carey Huebert, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

Dear Ms. Huebert:

This letter acknowledges receipt of your request for Informal Dispute Resolution (IDR) of the deficiency issued at a recent Minnesota Department of Health survey of your facility.

It is my understanding that you are contesting the validity of the following:

F323 = E

I have assigned the responsibility for the IDR to Pat Halverson. Pat will contact you with the results of our review or feel free to contact her 218-723-4637.

Sincerely,

A handwritten signature in cursive script, reading "Mary Absolon", is positioned below the "Sincerely," text.

Mary Absolon, Program Manager
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4100 FAX: (651) 215-9697

cc: Office of Ombudsman for Long-Term Care
Carol Moen, Assistant Program Manager
Pam Kerksen, Assistant Program Manager
Pat Halverson, Unit Supervisor
Monica Larson



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7497

May 8, 2012

Ms. Carey Huebert, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Subject: Golden LivingCenter - Rochester East - IDR
CMS Certification (CCN): 24-5184
Project # S5184024

Dear Ms. Huebert:

This is in response to your letter of April 4, 2012, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F323, 42 CFR 483.25(h) issued pursuant to the survey event LWM911, completed on March 1, 2012.

The information presented with your letter, the CMS 2567 dated March 1, 2012 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F323 (E) 42 CFR § 483.25(h) Accidents: The facility must ensure that the resident environment remains free from accident hazards as is possible;

The facility requested an IDR of F323 for the following reasons:

1. The residents identified in the deficiency were assessed for safe use of side rails for positioning.
2. The individual resident alleged risk factors were not identified in the deficiency.
3. Although the gap between the top of the side rail and the edge of the headboard is identified as zone 6 in the U.S. Department of Human Services Guidance for Industry and FDA Staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, there are no published dimensional guidelines.

Review of the pertinent information indicated:

R14 had bilateral 1/3 side rails on the bed. The zone 6 gap was measured at 12.5 inches and one of the side rails wobbled away from the bed with pressure. The deficiency lacked evidence that R14 was at risk for entrapment in the zone 6 gap or from the wobbly side rail.

May 8, 2012

Page 2

R6 had bilateral 1/2 side rails on the bed. R6 stated the side rails were used to move in bed. The side rail safety assessment did not address the zone 6 gap. In addition, the side rails were not securely fastened to the bed and wobbled away from the mattress with pressure. There was no evidence in the deficiency to indicate that R6 was at risk for entrapment in the zone 6 gap or from the wobbly side rails.

R1 had wobbly and cracked side rails on the bed. The deficiency lacked evidence to indicate that R1 was at risk for injury related to the condition of the side rails.

R117 had bilateral 1/2 side rails on the bed that were utilized for repositioning. The zone 6 gap was measured at 12.5 inches. There was no evidence to indicate that R117 was at risk for entrapment related to the zone 6 gap.

This is not a valid deficiency at this tag and will be removed from Statement of Deficiencies (CMS-2567 form).

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Facility and Provider Compliance
320 West Second Street, Suite #703
Duluth, Minnesota 55802
Telephone: (218) 723-4637 Fax: 218-723-2359

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Pat Halverson, Duluth District Office Unit Supervisor

5184S12.IDR

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

REVISED
5/8/12

PRINTED: 05/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately reassess pain management for 1 of 1 resident (R15) in the sample that experience chronic pain. Findings include: R15 had an increase in use of as needed pain medication from October 2011 to March 1, 2012 and did not have a pain reassessment completed to evaluate the pain regimen for optimal pain control. During an interview and observation on 2/27/12, at 4:27 p.m., R15 was lying in bed on her back holding the trapeze with her right hand and R15 verbalized pain mostly in left leg with no relief.	F 276		4/10/12	

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

TITLE

(X6) DATE

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

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F 276	Continued From page 1 During the interview with R15 she would hang on to the trapeze and grimace. R15 then said that there were painful spasms occur every 15 minutes which were not new and have been present for some time now. The quarterly Minimum Data Set (MDS) dated 12/8/11 was reviewed and compared with the quarterly MDS dated 9/12/11. The MDSs indicated R15 was clearly able to express ideas and wants; mild depression and no behaviors. The 12/8/11 MDS pain interview indicated R15 experienced almost constant pain that limited day to day activity, made it hard to sleep at night, and rated the pain at a "10" on a scale of 0-10, 10 as the worst pain imaginable. This was an increase in pain since 9/6/11. The comprehensive quarterly review dated 12/9/11 for the quarterly MDS indicated R15 had daily pain due to bilateral leg contractures and spasticity. On 3/1/12 at 1:56 p.m., the director of nursing verified that R15's pain should have been looked into and adjusted medications to be more effective. R15 needed another pain assessment completed.	F 276			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279			4/10/12

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F 279	Continued From page 2 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to develop care plan interventions that included restorative nursing for 1 of 3 residents (R89) in the sample reviewed for range of motion and the facility failed to develop interventions for residents at risk for bruising for 1 of 3 residents (R6) in the sample who had bruising. Findings Include: R89 had range of motion (ROM) ordered by the physician however, the care plan did not have any ROM interventions or directions to be followed by staff. R89 was admitted to the facility on 12/18/08, with diagnoses that included, but were not limited to: Alzheimer 's disease, dementia with behavioral disturbances and adult failure to thrive. Review of the physician orders revealed that the resident had the following range of motion exercise ordered since 7/2/09: Hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day.	F 279			

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F 279	Continued From page 3 Review of the residents current care plan dated 11/4/11, revealed that there was no care plan that identified the resident should have hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. During interview with the Registered Nurse Clinical Manager-A on 2/29/12, at 9:53 a.m. she confirmed that care plan interventions for the resident range of motion had not been developed. R6 was at risk to develop bruises and R6's care plan did not address this concern. R6 was observed at 4:56 p.m., on 2/27/2012, to have bruising on the back of both hands, forearms and finger. Primary Care Internal Med Nursing Home Limited Exam completed 7/12/11 by the certified nurse practitioner (CNP) indicated R6 had been experiencing an increase in bruising of forearms and hands. Review of quarterly Minimum Data Set (MDS) dated 2/8/12 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and required supervision with locomotion by wheelchair. MDS did not identify concern with bruising. Care plan dated 1/10/12 did not identify risk for bruising with interventions to decrease risk for bruising. During an interview at 11:22 a.m., on 2/29/12, clinical manager (CM)-B stated R6 does always	F 279			

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F 279	Continued From page 4 pay attention to where going and gets bruises from hitting hands and arms on things when moving around. CM-B stated there are no incident reports or nursing notes related to bruising on back of R6 's hands and forearms. CM-B indicated the bruising should have been assessed when found and documented. During an interview at 2:40 p.m., on 2/29/12, CM-B stated that she and the CNP believed the bruising was chronic and related to kidney disease.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate care and services for pain management for 1 of 3 residents (R15) in the sample reviewed for chronic pain. This resulted in actual harm to the resident. Additionally, The facility failed to comprehensively assess skin bruises for 2 of 3 residents (R49 and R6) in the sample who had skin conditions that were not pressure related. Findings include: R15 had ongoing chronic pain/spasms without	F 309			4/10/12

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F 309	Continued From page 5 consistent monitoring of the effectiveness of the pain medication, demonstrated an increase in pain intensity and fluctuating frequency of as needed (PRN) pain medication use for the past five months without a pain reassessment to determine optimal pain control for R15. R15 was admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a history of ongoing chronic pain rated at a 6 to 8 on a scale of 1 to 10, with 10 being the worst pain. During observations on 2/27/12, at 4:27 p.m. R15 was lying in bed on her back holding the trapeze with her right hand and grimacing at times. R15 verbalized pain mostly in left leg with no relief. During an interview at this time R15 said that she was having left leg spasms that occurred about every 15 minutes. R15 continued to say that the spasms have been occurring for months but have gotten worse lately and the pain medication did not always relieve the pain. During observation on 2/29/12 at 11:54 a.m. nursing assistant (NA)-B and NA-E were going to get R15 up for lunch and R15 requested to stay in bed due to having the diarrhea. During an interview at this time R15 indicated she was having pain and rated it at a 10/10. NA-B said that she would let licensed practical nurse (LPN) -B know about the pain. As NA-A lifted R15 in bed R15 began to crying and say "ouch" 6 times while being repositioned. R15 continued to cry out "ouch, oh my god". While NA-B and NA-E provided perineal care, R15 said "ouch" "oh my god" several times. On interview R15	F 309			

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F 309	Continued From page 6 complained of her leg hurting. NA-E then told R15 that the nurse would be bringing in her "oxy" (oxycodone) a pain medication. During an interview with NA-B following R15's cares at 12:11 p.m. it was learned that R15 typically complained of pain during cares. During observation on 3/1/12 at 7:18 a.m., NA-E entered room to get resident ready for breakfast. NA-E informed R15 that she was going to remove the gown and R15 said "Ouch" while the gown was removed. NA-E asked what was wrong and R15 stated my leg hurts and rated the pain at "7" on scale of 0-10. NA-E asked if R15 had any pain medication and R15 said they had given her some at 5 a.m., NA-E then said that it must have not kicked in yet. NA-E continued to complete cares for R15. R15 said "ouch, that hurts", several times with movement. During an interview after R15's cares, NA-E said that R15 always felt "crampy" [having feeling of pain] and R15 preferred to stay in bed a lot and frequently refused to be repositioned. A quarterly Minimum Data Set (MDS) (a resident assessment and care screening tool) was completed 12/8/11. The MDS indicated that R15 was able to clearly express ideas and wants. A brief interview for mental status (BIMS) (cognitive assessment) was completed and R15 scored 11 out of 15 which indicated moderate impairment in mental status. The MDS also indicated R15 had almost constant pain that made it hard to sleep at night and limited day-to-day activities. R15 had rated the pain as a 10 however the intensity section of the pain section had not been completed on this MDS. R15's care plan date initiated 1/11/11 and revised on 12/9/11, indicated that R15 had identified pain management needs and	F 309			

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F 309	Continued From page 7 monitoring needs related to generalized deconditioning (decline), bilateral knee contractures (which R15 was admitted with) due to mild Parkinson ' s disease, seizure disorder and left ulnar neuropathy with a goal to maintain adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain, distress or verbalizing satisfaction with level of comfort. There had been no new pain interventions added to the care plan since 1/11/11. Review of R15 ' s current physician orders dated 1/24/12 revealed that R15 had the following pain medications: neurontin 400 milligram (mg) (used for chronic pain and neuralgia) three times a day, oxycodone hydrochloride 10 mg every day, oxycodone hydrochloride 5 mg every day, oxycodone hydrochloride 5 mg every three hours as prn (needed), Tylenol extra strength 1000 mg three times a day, baclofen 7.5 mg (used for treatment of spasticity) three times a day. The quarterly clinical health status form dated 9/23/11 completed by registered nurse (RN) clinical manager-B indicated R15 had constant, burning, aching, throbbing pain in legs and back with a pain rating of " 7 " on a scale of 1-10. R15 ' s acceptable level of pain was 6. The documentation indicated that the pain impacted quality of life, sleep, functioning and mood. The clinical health status form identified " current pain treatment plan: tylenol, oxycodone, repositioning " " Effective " . The quarterly clinical health status form dated 12/9/11 at 8:00 a.m. completed by registered nurse (RN) -B indicated R15 had constant, sharp pain in left hip and thigh with a pain rating of " 6 " on a scale of 1-10. R15 ' s acceptable level of pain was " 4 " on scale of 0-10. The documentation indicated that the pain impacted	F 309			

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F 309	Continued From page 8 quality of life by limiting activities. The clinical health status form identified " current pain treatment plan: oxycodone, baclofen, sinemet " " Effective " . During review of the medication administration record (MAR) along with the pain monitoring tool, the following was noted concerning R15 ' s use of as needed pain medication: July 2011, R15 had received 7 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 8 to 10. August 2011, R15 had received 13 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 6 to 10. September 2011, R15 had received 3 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 8 to 10. October 2011, R15 had received 13 PRN doses of oxycodone 5 mg for pain rating ranging from 7 to 10. November 2011 it revealed 41 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. December 2011 revealed 38 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. January 2012 revealed 25 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. For the month of February 2012 it revealed 17 PRN doses of oxycodone 5 mg had been given for pain rating ranging from 7-10. Upon review of the effectiveness of the PRN pain medication from July 2011 to March 1, 2012, it was noted that numerous doses of pain medication had not been evaluated for effectiveness. A review of progress notes indicated the following concerns with pain as follows: On 10/20/11 at 9:17 p.m., written by licensed practical nurse (LPN)-A indicated that resident R15 was alert, orientated, and able to communicate her needs to staff ...Resident complained of pain of 8 out of 10. R15 received a	F 309			

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F 309	Continued From page 9 scheduled tylenol and oxycodone. However, there had been no follow up documentation on the effectiveness of these pain medications. On 11/21/11 at 14:51 (2:51 p.m.), written by registered nurse (RN)-D said that R15 received prn oxycodone 5 mg at 10:00 a.m. for pain in legs which had been rated 10 out of 10 (worst pain possible.) Follow up rating was 7 out of 10. On 11/24/11 at 11:39 p.m. written by RN-E said that the resident continued to complain about pain affecting both legs, pain rating at a 9 to 10. This was two hours after the resident received as needed oxycodone. No other interventions or follow up was noted following the complaint of severe pain not being relieved. On 12/1/11 at 10:26 p.m. written by LPN-A said that R15 offered complaints of pan in hip and legs this evening at 9:30 p.m. and received an as needed oxycodone 5 mg. No follow up documentation on the effectiveness of pain medication was documented. On 2/23/12 at 2:21 p.m. written by LPN-B revealed resident was alert and oriented, resident refused shower this shift due to pain and resident rated pain at an 8. LPN-B administered prn oxycodone and it had provided little relief. During an interview on 3/1/12 at 7:11 a.m., RN-C, who worked the night shift, indicated that the previous shift had given R15 pain medication around 9 p.m. the evening before and then RN-C usually gives another as needed pain dose around 4:00 a.m. RN-C stated she had not noticed any changes in pain, just that the pain increased with movement. Staff would offer reassurance, deep breathing and repositioning. R15 usually rated her pain as 8-10. RN-C stated she would go back in R15 's room to check on the resident about an hour after prn pain	F 309			

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F 309	Continued From page 10 medication was given and R15 was usually sleeping. RN-C said that R15 was repositioned every 2 hours during the night shift and usually complained of pain during repositioning. During an interview on 3/1/12 at 7:55 a.m., registered nurse clinical manager (RNCM)-A who had worked the day shift, verified that R15 had chronic pain and received pain medication. RNCM-A verified that R15 had an order for oxycodone 10 mg at 6 a.m. and 5 mg at 5 p.m. and an order for oxycodone 5 mg every 3 hours as needed for pain, along with routine tylenol extra strength. RNCM-A confirmed that R15 had been on this combination of medications for quite some time. RNCM-A stated that the licensed nurses would let RNCM-A know of any changes in R15 ' s pain and prn medication frequency and then she would let the nurse practitioner know. The nurse practitioner would than look for frequently used prn medications and if the pain was controlled with the scheduled medications than may need to adjust times and doses. When asked about the increase in PRN oxycodone medication use from October 2011 to current date (March 1, 2012), the RNCM-A indicated that she was unaware of the frequency of use. RNCM-A felt that R15 ' s pain was managed as well as it can be managed and that R15 came to the facility with the contractures and chronic pain. On 3/1/12 at 8:42 a.m., a family member (F1) was interviewed and confirmed R15 had experienced a lot of pain and there were times where the pain did go away. F1 indicated that mornings were rough for R15. F1 indicated that pain management had been discussed during quarterly care conferences and it was said that when R15 begins to feel pain she was to put on the call light. F1 indicated that R15 had rated the	F 309			

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F 309	Continued From page 11 pain from 8-10. F1 indicated that they were not aware of any discussion on other options available for pain management for the past several months. F1 discussed bringing up acupuncture as an option for pain relief to the facility and felt it may be a good idea that R15 be reevaluated for pain control. On 3/1/12 at 1:23 p.m., R15 's primary medical doctor (MD) was contacted and verified that R15 had a diagnosis of thoracic neuropathy and felt that pain management had been thoroughly addressed. The MD said that she and the nurse practitioner discussed the resident 's current health conditions, medications R15 currently receives and possible side effects. They had also discussed the possible use of an anti-Parkinson 's medication to help with mobility. When asked about the pain management for R15, MD indicated that she would expect the facility staff to update her if there was a change in R15 's pain so further evaluation could be done. On 3/1/12 at 1:56 p.m., the Director of Nursing (DON) was interviewed and indicated that R15 gets very nervous and anticipatory of pain any time staff want to move her. The DON indicated that staff administers pain medication before moving R15. When questioned about R15 's ongoing use of prn pain medication and lack of monitoring of medication effectiveness since October 2011, the DON said that she would expect the staff to inform the NP to assess the resident 's pain management regimen. The DON indicated the staff needed to complete a comprehensive pain assessment on R15 as soon as possible and have the NP reviews it to evaluate the effectiveness of the pain regimen.	F 309			

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F 309	Continued From page 12 During a telephone interview on 3/2/12 at 8 " 18 a.m., the NP responsible for R15 ' s care, indicated that R15 would never fully get rid of pain and spasms, that she was aware the spasms were worse in the morning and when applying braces on both legs, and indicated the spasms/pain got better throughout the day. The NP indicated R15 received oxycodone before cares were provided and before putting on the leg braces. NP indicated R15 had been seen by her on 1/30/12 and R15 ' s pain management was evaluated and seemed to be the best at this time. NP indicated that there had been no nursing concerns expressed to her in regards to R15 ' s pain management. NP verified she had not been informed by nursing staff of the lack of pain medication effectiveness from October 2011 through February 2012. NP indicated that she evaluated the underlying condition/s for R15 ' s medication regimen especially how they affect the heart and kidney function. NP verified that physical therapy interventions had been attempted over the past year for R15. R49 had bruising that was not identified or monitored. R49 was admitted to the facility on 6/18/10 with diagnoses including cerebral vascular disease with hemiplegia, recurrent thromboembolism, and debility and received anticoagulant medications. On 2/27/12 at 7:19 p.m., R49 had a bruise on outer aspect of left arm above the elbow. R49 was unaware of the bruise and how it had happened.			F 309			

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F 309	Continued From page 13 Review of the resident's record did not show any documentation of the bruised area on the left arm. R49 ' s care plan with date initiated 10/25/10 was reviewed and it indicated R49 was at risk for complications related to anticoagulant medication secondary to diagnosis of recurrent thromboembolism and history of CVA (cardio-vascular attack or stroke). Interventions included observe for signs and symptoms of bleeding: tarry stools, blood in urine, bruising, petechiae. On 3/1/12 at 8:36 a.m., registered nurse (RN) clinical manager-B indicated she was unaware of a bruise and verified that there was no documentation regarding a bruise on his arm and that she would go and assess the area at this time. On 3/1/12 at 9:13 a.m., RN-B indicated that when staff identified bruises it was to be reported to the nurse manager and the executive director. Staff perform an investigation, measure the area, document and investigate further to make sure resident was safe. Staff performs a skin inspection weekly and nursing assistants are to let the nurses know if bruises are noted during cares. On 3/1/12 at 1:49 p.m., director of nursing (DON) confirmed the clinical manager would take measurements, talk with resident to ensure no abuse and investigate what happened when a bruise had been identified.	F 309			

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F 309	Continued From page 14 R6 lacked a skin assessment and monitoring of a bruise. R6 was observed at 4:56 p.m., on 2/27/2012, to have bruising on the back of both hands, forearms and finger. Incident reports were reviewed from 12-11-11 to 2-11-12 and no reports identified bruises on the resident. Primary Care Internal Med Nursing Home Limited Exam completed 7/12/11 by the certified nurse practitioner (CNP) indicated R6 had been experiencing an increase in bruising of forearms and hands. Review of quarterly Minimum Data Set (MDS) dated 2/8/12 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and required supervision with locomotion by wheelchair. MDS did not identify concern with bruising. Care plan dated 1/10/12 did not identify risk for bruising with interventions to decrease risk for bruising. During an interview at 11:22 a.m., on 2/29/12, clinical manager (CM)-B stated R6 does always pay attention to where going and gets bruises from hitting hands and arms on things when moving around. CM-B stated there are no incident reports or nursing notes related to bruising on back of R6 's hands and forearms. CM-B indicated the bruising should have been assessed when found and documented. During an interview at 2:40 p.m., on 2/29/12, CM-B stated that she and the CNP believed the	F 309			

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F 309	Continued From page 15	F 309			
F 318 SS=D	bruising was chronic and related to kidney disease. 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure range of motion was provided according to the assessed needs for 2 of 3 residents (R89 and R6) in the sample reviewed for range of motion. Findings include: R89 did not receive range of motion (ROM) services according to their assessed needs. R89 was admitted to the facility on 12/18/08, with diagnoses that included, but were not limited to: Alzheimer disease, dementia with behavioral disturbances and adult failure to thrive. Review of the physician orders revealed that the resident had the following range of motion exercise ordered since 7/2/09: Hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. Review of the restorative documentation record	F 318			4/10/12

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F 318	Continued From page 16 for R89 for the month of February 2012 revealed that of 58 opportunities the hamstring stretches were completed "0" zero times. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident ' s refusal. Review of the restorative documentation record for R89 for the month of January 2012 revealed that of 62 opportunities, the hamstring stretches were completed "22" twenty-two opportunities. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident ' s refusal. Review of the restorative documentation record for R89 for the month of December 2011 revealed that of 62 opportunities, the hamstring stretches were completed "24" twenty-four opportunities. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident ' s refusal. During interview with the Registered Nurse Clinical Manager-A on 2/29/12, at 9:53 a.m. She confirmed that the resident should be having hamstring stretch with feet up on chair/lowered bed for 5-10 minutes offered twice a day. She confirmed that the rehab program was not consistently implemented and the nursing assistant assigned to the residents care should have written an explanation of why the range of motion exercise or reasons for refusal on the restorative record if the range of motion exercise was not completed.	F 318			

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F 318	Continued From page 17 Resident (R6) lacked development of restorative nursing/range of motion per physical therapy recommendation. R6 was admitted on 6/15/2010, with diagnoses that included but are not limited to history of stroke, history of hip fracture and joint replacement and osteoarthritis. At 11:47 a.m., on 2/29/12, R6 was observed during a transfer from a sitting position to a standing position. R6 was observed to perform a pivot transfer with assist of staff. R6 knees were bent and together. Hinged brace was in place on left knee. Interview with R6 at 4:43 p.m., on 2/27/12 and R6 stated she needed staff assistance to get in and out of bed. Review of quarterly Minimum Data Set (MDS) dated 2/8/12, revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene. MDS did not indicate use of restorative nursing programs. Care plan print date of 1/10/12, lacked care plan interventions for range of motion/restorative nursing. Rehab Recommendations dated 9/8/11 included hamstring stretches twice a day after each meal. Rehab Recommendations dated 1/27/12, included " after each meal, lower the bed, put feet up to stretch hamstrings/knees. Remind [R6] to relax and push knees straight 10-15 [times]. " Physical therapy program coordinator was interviewed at 3:21 p.m., on 2/29/12 and indicated	F 318			

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F 318	Continued From page 18 therapy sets up restorative programs. Physical therapy program coordinator stated R6 was discharged from therapy on 2/24/11 and was to continue with restorative exercises. She indicated procedure was for therapy to hand over the restorative program to the clinical managers. Restorative Guideline procedure (undated) was reviewed. Restorative nurse coordinator with input from therapy makes resident selections. Restorative coordinator initiates the restorative nursing worksheet and restorative nursing staff document on the worksheet. Restorative nursing worksheets for December 2011, January 2012 and February 2012 did not identify therapy recommendations for hamstring stretches. During an interview on 3/1/12, 9:15 a.m., with clinical manager (CM)-B, CM-B indicated she was in charge of the restorative program on second floor and stated she has not been monitoring for compliance. CM-B verified documentation of restorative program for R6 was not completed consistently. CM-B verified the hamstring program was not included in the restorative program as recommended by physical therapy. CM-B stated she received education on 3/1/12 from a clinical consultant on restorative programs. CM-B stated she plans to start monitoring the restorative program for compliance and effectiveness.	F 318			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329			4/10/12

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F 329	Continued From page 19 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate monitoring for effectiveness of narcotic usage for 1 of 1 resident (R15), adequate indications for anti-depressant medication for insomnia for 1 of 1 resident (R117) and lacked laboratory tests for anti-cholesterol medications for 1 of 10 residents (R6) in the sample. Findings include: R15 received oxycodone (a narcotic pain medication), but lacked monitoring of the effectiveness of the medication.	F 329			

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F 329	Continued From page 20 R15, admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's disease, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a physician's order for oxycodone hydrochloride 5 mg every three hours prn (as needed) for pain. Review of the medication administration record (MAR) revealed that resident had received oxycodone 5 mg every three hours prn for pain. The documentation was not completed for the effectiveness of the pain medication. Review of November 2011 MAR revealed that R15 had received oxycodone prn 41 times and had follow-up documentation only 26 times and included pain rating only 5 times in follow up documentation. Review of December 2011 MAR revealed that R15 had received oxycodone prn 38 times and had follow-up documentation 20 times, but included pain rating only 3 times. Review of January 2012 MAR revealed that R15 had received oxycodone prn 25 times with follow-up documentation done 16 times, but included pain rating 1 time. Did not receive prn sheet for the month of February that was requested on 3/1/12 and 3/2/12. Review of MAR revealed that R15 had an increased usage of oxycodone since November 2011. On 3/1/12 at 7:55 a.m., RN clinical manager-B verified that R15 had chronic pain and received pain medication. RN clinical manager verified that R15 had an order for oxycodone 5 mg every 3 hours as needed for pain. RN clinical manager revealed that the licensed nurses would let the RN clinical manager know of any changes in pain and prn frequency and then would let the nurse	F 329			

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F 329	Continued From page 21 practitioner know to review. The nurse practitioner would than look for frequently used prn medications and if the pain was controlled with the scheduled medications than may need to adjust times and doses. RN clinical manager indicated that she was unaware of any changes in the amount of prn usage for the past few months for R15. RN clinical manager felt that R15's pain was managed as well as it can be managed. On 3/1/12 at 1:56 p.m., Director of Nursing (DON) was interviewed and indicated that R15 gets very nervous and anticipatory of pain any time staff want to move her. DON would expect the staff to take the information to the NP if using excessive prn medications and would bump up the medication to something more effective. DON verified that the staff need to get another pain assessment done and into the NP as soon as possible. R117 received trazodone (an antidepressant used as a sleeping aid) for insomnia without adequate indications. A review of documents revealed the physician ordered trazodone 50 mg. orally at bed time for insomnia on 4/11/2011. The physician ordered increases to the medication up to 200 mg at bedtime and then on 10/19/2011, the physician ordered a decrease to 100 mg orally at bed time. R117 was currently receiving the 100 mg dose at bedtime. A physician note dated 4/11/2011 was reviewed. It noted "patient has a main complaint to me today of insomnia. " "Would like to start a low dose of trazodone" On 2/29/2012 at 11:30 a.m., Clinical Manager	F 329			

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F 329	Continued From page 22 (CM)-A was interviewed. She indicated the resident was admitted on 3/31/2011 and the trazodone medication initially was started on 4/11/2011, increased several times and then decreased to 100 mg for insomnia. The CM verified a sleep assessment should have been done initially but it had not been done. The facility policy and procedure for Sleep Problems, undated, indicated the team needed to assess the resident's routine and customary habits to determine if the sleep disturbance was a problem. R6 lacked blood laboratory results for use of anti-cholesterol medications and diabetes management and Certified Nurse Practitioner (CNP) notification of blood glucose levels out of identified range. R6 was admitted to the facility on 6/15/2010 and had diagnosis that included but not limited to: hypoglycemia, chronic kidney disease, diabetes. R6 had physician orders dated 6/15/10 for Simvastatin 10 mg at bedtime for high lipid levels. Insulin NPH 20 units ordered 5/9/11 for diabetes management. Reviewed laboratory results identified in clinical record dated 7/18/11 and laboratory results lacked monitoring of cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). On 3/1/12, at 12:45 p.m. clinical manager (CM)-B was interviewed and indicated medication procedure was to obtain laboratory results twice a year. She indicated that she was unable to find	F 329			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
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F 329	Continued From page 23 cholesterol results. Physician order dated 11/20/11 directed staff to test the resident ' s blood glucose levels twice daily and to notify the CNP if blood glucose levels were less than 100 or greater than 150. Review of medication administration record (MAR) for R6 revealed in February 2012 R6 experienced blood glucose levels in excess of 150 for periods of three to six consecutive days three times during the month and these had not been reported to the CNP.	F 329			
F 412 SS=D	On 3/1/12, at 12:45 p.m. CM-B verified CNP was not notified of elevated glucose levels. 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to reassess oral health status and provide dental services for 1 of 1 resident (R132) in the sample who had complaints of teeth pain. Findings include:	F 412			4/10/12

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F 412	Continued From page 24 R132 voiced complaints of multiple tooth pain that had not been assessed and dental services had not been provided timely. R132 was observed on 2/28/12 at 9:17 a.m. during which it was noted that the resident had multiple broken and carious teeth. It was noted that a thick layer of white debris coated the resident 's teeth. During interview with the resident at that time he stated that he had pain in his teeth. Review of the nursing progress notes for the month of February 2012 revealed that there were no comments or assessment of oral status or tooth pain for R132. Registered Nurse (RN) Clinical Manager B was interviewed on 3/1/12 at 8:20 a.m. during which she confirmed that the resident had complained of tooth pain the previous week she confirmed that the residents medical record did not contain comments or assessment of oral status or tooth pain for R132. RN clinical manager B did state that she notified the nurse practitioner of the issue but the resident 's record did not contain any evidence that the nurse practitioner had addressed the concern. RN clinical manager B provided documentation of a nurse practitioner visit entered on 3/1/12, at 1:12 p.m. that identified the following:"2/24/12, [RN clinical manager B] informs me that pt had c/o tooth ache to tablemate. Pt has missing teeth, no drainage, no redness, no swelling, no fever. Pt is eating and drinking without difficulty. Pain apparently is intermittent on the right side, but is unable to pinpoint or c/o any pain when asked.	F 412			

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F 412	Continued From page 25 advised nonemergent dental appt. notify me of any increase in [symptoms] esp [especially] swelling..." Review of the care plan (unable to find date in electronic medical record) the following interventions were identified related to dental: Assistance with oral care as needed. Inspect oral cavity for bleeding of gums or other issues. Medication and or treatment as ordered. Refer for Dental services as needed. Further interview with Registered Nurse (RN) Clinical Manager B was interviewed on 3/1/12, at 8:20 a.m. she stated that she put the resident on the list for a dental exam for the next time the contracted dental services were coming to the facility but did not know when that would be. The clinical manager then called the director of nursing and asked her when the dental company who provides the facility with routine dental services was coming to the building and she stated that she did not know and that they would get back to me. The director of nurses came back on 3/1/12 at approximately 8:45 a.m. and stated that the contracted dental services were not scheduled to come to the facility for routine dental care until 3/13/12 (18 days after the resident complained of tooth pain.)	F 412			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428			4/10/12

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F 428	Continued From page 26 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility consultant pharmacist failed to identify irregularities and report them to the physician and director of nursing concerning adequate monitoring for effectiveness of narcotic usage for 1 of 1 resident (R15), adequate indications for anti-depressant medication for insomnia for 1 of 1 resident (R117) and lacked laboratory tests for anti-cholesterol medications for 1 of 10 residents (R6). Findings include: R15 received received oxycodone (a narcotic pain medication), but lacked monitoring of the effectiveness of the medication. R15, admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a physician's order for oxycodone hydrochloride 5 mg every three hours as prn (needed) for pain. Review of the medication administration record (MAR) revealed that resident had received oxycodone 5 mg every three hours prn for pain. The documentation was not completed for the effectiveness of the pain medication. Review of November MAR revealed that R15 had received oxycodone prn 41 times and had follow-up	F 428			

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F 428	Continued From page 27 documentation 26 times, but included pain rating only 5 times in follow up documentation. Review of December MAR revealed that R15 had received oxycodone prn 38 times and had follow-up documentation 20 times, but included pain rating only 3 times. Review of January MAR revealed that R15 had received oxycodone prn 25 times with follow-up documentation done 16 times, but included pain rating 1 time. Did not receive prn sheet for the month of February that was requested on 3/1/12 and 3/2/12. Review of MAR revealed that R15 had an increased usage of oxycodone since November. On 3/1/12 at 1:02 p.m., interview with pharmacy consultant revealed that the increase in oxycodone was not addressed. Pharmacy consultant indicated that he would not be concerned about the increase in prn pain medication but would be concerned about constipation and fall side effects. He indicated that he did not feel the lack of identification of the increased prn pain medication was a big deal. R117 was on trazodone medication used as a sleep aid for insomnia. No sleep assessment to identify patterns or routine of sleep was completed prior to initiation of the sleep aid medication. According to physician orders dated 10/19/2011, R117 was receiving Trazodone 100 mg. at bedtime for insomnia. Pharmacy reviews dated 4/28/2011 through 2/2012 were reviewed. The pharmacy reviews addressed the use of trazedone but did not address the need for a sleep assessment.	F 428			

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F 428	Continued From page 28 On 2/29/2012 at 11:30 a.m., Clinical Manager (CM)-A was interviewed. She indicated the resident was admitted on 3/31/2011 and the trazodone medication initially was started on 4/11/2011, increased several times, and then decreased to 100 mg. for insomnia. The CM verified a sleep assessment should have been done initially but it had not been done. R6 lacked consultant pharmacist identification of irregularities related to laboratory results and diabetes management. R6 was admitted to the facility on 6/15/2010 and had diagnosis that included but not limited to: hypoglycemia, chronic kidney disease, diabetes. R6 had physician orders dated 6/15/10 for Simvastatin 10 mg at bedtime for high lipid levels. Insulin NPH 20 units ordered 5/9/11 for diabetes management but lacked laboratory results monitoring cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). Physician order dated 11/20/11 directed staff to test the resident's blood glucose levels twice daily and to notify the CNP if blood glucose levels were less than 100 or greater than 150. Review of medication administration record (MAR) for R6 revealed in February 2012 R6 experienced blood glucose levels in excess of 150 for periods of three to six consecutive days three times during the month. Reviewed laboratory results identified in clinical record dated 7/18/11 and laboratory results lacked monitoring of cholesterol levels and A1C	F 428			

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F 428	Continued From page 29 levels. (Laboratory results used to monitor diabetes management). On 3/1/12, at 12:45 p.m., clinical nurse manager -B was interviewed and indicated medication procedure was to obtain laboratory results twice a year. She indicated that she was unable to find cholesterol results and verified CNP was not notified of elevated glucose levels. The consultant pharmacist (CP) was interviewed by telephone at 3:10 p.m., on 3/2/12. CP stated a baseline liver functioning test is completed one time and recommends every six months after. CP stated cholesterol panel guideline is for completion of a cholesterol panel yearly and stated again he recommends every six months. CP stated A1C was not needed for blood glucose monitoring. He stated he reviews blood sugars and makes recommendations as needed.	F 428			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441			4/10/12

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F 441	Continued From page 30 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to maintain an infection control program that would analyze infection trends and patterns of infections in the facility in order to prevent, recognize, and control the spread of infection. This had the potential to affect all 102 of 102 residents in the facility. Findings include: The facility's " Line Listing of Resident Infection " surveillance forms were reviewed for October, November and December 2011. The surveillance sheets was to include the following information: resident name, room number and unit, admission date, type of infection, date and onset of symptoms, cultures (including date done, site and	F 441			

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F 441	Continued From page 31 result), treatment to include type of medication and when the infection was resolved, and whether or not an infection is nosocomial (infections that develop as a result of a stay in hospital.) The infection control surveillance forms were consistently not completed in an organized, legible and systematic manner and revealed the following: October 2011: 24 out of 25 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. November 2011: 10 out of 12 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. December 2011: 22 out of 22 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. On 3/1/2012, at 1:21 p.m. the Infection Control Nurse (ICN) was interviewed and confirmed the "Line Listing of Resident Infections" forms were not complete with the information to aide in analysis and tracking of resident infections. The ICN confirmed there was a lack of consistency related to data collection and analysis of the information. On 3/1/2012, at 3:00 p.m. the director of nursing (DON) was interviewed regarding the infection control program. The DON stated the program	F 441		

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F 441	Continued From page 32 "was not where it needs to be" because the ICN was also responsible for hiring new employees and that was more of a priority. The facility's policy/procedure titled " Introduction Infection Control in Long-Term, Care " dated 2001 with a revision date of October 2011. The policy indicated that the infection control program should have components to include employee health, environmental infection control, and surveillance and reporting, managing the infection control aspects of various clinical conditions, and immunization and vaccination.	F 441			

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245184	(Y2) Multiple Construction A. Building B. Wing	REVISED 5/8/12	(Y3) Date of Revisit 4/16/2012
Name of Facility GOLDEN LIVINGCENTER - ROCHESTER EAST		Street Address, City, State, Zip Code 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0276 Reg. # 483.20(c) LSC	Correction Completed 04/10/2012	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 04/10/2012	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 04/10/2012
ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 04/10/2012	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 04/10/2012	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 04/10/2012
ID Prefix F0412 Reg. # 483.55(b) LSC	Correction Completed 04/10/2012	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 04/10/2012	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 04/10/2012
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 3/1/2012		☐ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately reassess pain management for 1 of 1 resident (R15) in the sample that experience chronic pain. Findings include: R15 had an increase in use of as needed pain medication from October 2011 to March 1, 2012 and did not have a pain reassessment completed to evaluate the pain regimen for optimal pain control. During an interview and observation on 2/27/12, at 4:27 p.m., R15 was lying in bed on her back holding the trapeze with her right hand and R15 verbalized pain mostly in left leg with no relief.	F 000	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>		
F 276 SS=D		F 276	F276 - Resident # 15 has had a new pain assessment on 3/9/12 and NP has adjusted pain medications. - All residents at facility have the potential to be effected by these practices. Pain assessments shall be completed on admission, quarterly and with change of condition on residents at GLCC RE.		

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

TITLE

(X6) DATE

Chuebert

Executive Director

4/4/12

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.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 276	Continued From page 1 During the interview with R15 she would hang on to the trapeze and grimace. R15 then said that there were painful spasms occur every 15 minutes which were not new and have been present for some time now. The quarterly Minimum Data Set (MDS) dated 12/8/11 was reviewed and compared with the quarterly MDS dated 9/12/11. The MDSs indicated R15 was clearly able to express ideas and wants; mild depression and no behaviors. The 12/8/11 MDS pain interview indicated R15 experienced almost constant pain that limited day to day activity, made it hard to sleep at night, and rated the pain at a "10" on a scale of 0-10, 10 as the worst pain imaginable. This was an increase in pain since 9/6/11. The comprehensive quarterly review dated 12/9/11 for the quarterly MDS indicated R15 had daily pain due to bilateral leg contractures and spasticity. On 3/1/12 at 1:56 p.m., the director of nursing verified that R15's pain should have been looked into and adjusted medications to be more effective. R15 needed another pain assessment completed.	F 276	- Nursing staff shall be educated on pain management and notifying NP/MD if analgesics and non pharmacological interventions are not effected in relieving pain. In-service to include alerting NP/MD if a resident has been utilizing prn medication on a more than 7 times in a 7 day period. MD/NP to review if scheduled medication or dose increases are indicated. - DNS/Designee will audit pain flow sheets to assure that nurses education has been effective. - Audits will be reviewed at QAA x 3 months. - All items to be corrected by 4/10/12.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279			4/10/12

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F 279	Continued From page 2 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to develop care plan interventions that included restorative nursing for 1 of 3 residents (R89) in the sample reviewed for range of motion and the facility failed to develop interventions for residents at risk for bruising for 1 of 3 residents (R6) in the sample who had bruising. Findings include: R89 had range of motion (ROM) ordered by the physician however, the care plan did not have any ROM interventions or directions to be followed by staff. R89 was admitted to the facility on 12/18/08, with diagnoses that included, but were not limited to: Alzheimer ' s disease, dementia with behavioral disturbances and adult failure to thrive. Review of the physician orders revealed that the resident had the following range of motion exercise ordered since 7/2/09: Hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day.	F 279	• F279 • Resident # 6 and #89 have had their care plans updated to include their current restorative/functional nursing interventions and interventions to prevent skin from bruising. • Resident #6 was at risk to bruising d/t being on ASA, which can contribute to bruising. • No negative effects have occurred to resident # 89 for not having nursing restorative/functional needs care planned. Resident #6 is noted to be at risk from bruising and interventions have been put in place to prevent bruising. • All residents who need a restorative or functional program are effected by this practice. All resident on anti-coagulation therapy are at risk for bruising.	

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F 279	Continued From page 3 Review of the residents current care plan dated 11/4/11, revealed that there was no care plan that identified the resident should have hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. During interview with the Registered Nurse Clinical Manager-A on 2/29/12, at 9:53 a.m. she confirmed that care plan interventions for the resident range of motion had not been developed. R6 was at risk to develop bruises and R6's care plan did not address this concern. R6 was observed at 4:56 p.m., on 2/27/2012, to have bruising on the back of both hands, forearms and finger. Primary Care Internal Med Nursing Home Limited Exam completed 7/12/11 by the certified nurse practitioner (CNP) indicated R6 had been experiencing an increase in bruising of forearms and hands. Review of quarterly Minimum Data Set (MDS) dated 2/8/12 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and required supervision with locomotion by wheelchair. MDS did not identify concern with bruising. Care plan dated 1/10/12 did not identify risk for bruising with interventions to decrease risk for bruising. During an interview at 11:22 a.m., on 2/29/12, clinical manager (CM)-B stated R6 does always	F 279	- Residents on the restorative and functional programs will have a care plan implemented at start of the program and updated quarterly. All resident on these programs will have their care plan reviewed quarterly in the ARD period to assure the POC addresses the program. Residents on anti-coagulation therapy are at risk for bruising and will have a care plan put in place with interventions to prevent bruising. - This will be completed by 4/10/12. - DNS/designee will complete weekly audits to assure system stated is in effect. - Facility will review audits at QAA x 3 months.	4/10/12

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F 279	Continued From page 4 pay attention to where going and gets bruises from hitting hands and arms on things when moving around. CM-B stated there are no incident reports or nursing notes related to bruising on back of R6 's hands and forearms. CM-B indicated the bruising should have been assessed when found and documented. During an interview at 2:40 p.m., on 2/29/12, CM-B stated that she and the CNP believed the bruising was chronic and related to kidney disease.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate care and services for pain management for 1 of 3 residents (R15) in the sample reviewed for chronic pain. This resulted in actual harm to the resident. Additionally, The facility failed to comprehensively assess skin bruises for 2 of 3 residents (R49 and R6) in the sample who had skin conditions that were not pressure related. Findings include: R15 had ongoing chronic pain/spasms without	F 309	F309 - Resident # 15 has been reassessed for pain on 3/9/12 and a new pain management regime has been ordered. Resident # 6 and # 49 have had skin assessment completed and are documented on. - All residents at facility have potential to be effected by this cited deficient practice.		

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F-309	Continued From page 5 consistent monitoring of the effectiveness of the pain medication, demonstrated an increase in pain intensity and fluctuating frequency of as needed (PRN) pain medication use for the past five months without a pain reassessment to determine optimal pain control for R15. R15 was admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a history of ongoing chronic pain rated at a 6 to 8 on a scale of 1 to 10, with 10 being the worst pain. During observations on 2/27/12, at 4:27 p.m. R15 was lying in bed on her back holding the trapeze with her right hand and grimacing at times. R15 verbalized pain mostly in left leg with no relief. During an interview at this time R15 said that she was having left leg spasms that occurred about every 15 minutes. R15 continued to say that the spasms have been occurring for months but have gotten worse lately and the pain medication did not always relieve the pain. During observation on 2/29/12 at 11:54 a.m. nursing assistant (NA)-B and NA-E were going to get R15 up for lunch and R15 requested to stay in bed due to having the diarrhea. During an interview at this time R15 indicated she was having pain and rated it at a 10/10. NA-B said that she would let licensed practical nurse (LPN) -B know about the pain. As NA-A lifted R15 in bed R15 began to crying and say "ouch" 6 times while being repositioned. R15 continued to cry out "ouch, oh my god". While NA-B and NA-E provided perineal care, R15 said "ouch" "oh my god" several times. On interview R15	F 309	- Nursing staff shall be educated on pain management and notifying NP/MD if analgesics and non pharmacological interventions are not effected in relieving pain. In-service to include alerting NP/MD if a resident has been utilizing prn medication on a daily basis. MD/NP to review if scheduled medication or dose increases are indicated. NAR's shall receive education related on reporting pain during cares to LN and how to continue or if needed to stop cares due to residents pain levels. In Service related to skin care assessment shall be provided to nursing staff to enhance their skin assessment skills. LN to observe resident skin Q week on shower day. Skin assessments shall be completed on admission, quarterly and with a change of condition. - DNS/Designee will audit pain flow sheets to assure that nurses education on pain management has been effective. DNS/Designee will review all new admissions, quarterly reviews and change of condition for residents skin status.	

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F.309	Continued From page 6 complained of her leg hurting. NA-E then told R15 that the nurse would be bringing in her "oxy" (oxycodone) a pain medication. During an interview with NA-B following R15's cares at 12:11 p.m. it was learned that R15 typically complained of pain during cares. During observation on 3/1/12 at 7:18 a.m., NA-E entered room to get resident ready for breakfast. NA-E informed R15 that she was going to remove the gown and R15 said "Ouch" while the gown was removed. NA-E asked what was wrong and R15 stated my leg hurts and rated the pain at "7" on scale of 0-10. NA-E asked if R15 had any pain medication and R15 said they had given her some at 5 a.m., NA-E then said that it must have not kicked in yet. NA-E continued to complete cares for R15. R15 said "ouch, that hurts", several times with movement. During an interview after R15's cares, NA-E said that R15 always felt "crampy" [having feeling of pain] and R15 preferred to stay in bed a lot and frequently refused to be repositioned. A quarterly Minimum Data Set (MDS) (a resident assessment and care screening tool) was completed 12/8/11. The MDS indicated that R15 was able to clearly express ideas and wants. A brief interview for mental status (BIMS) (cognitive assessment) was completed and R15 scored 11 out of 15 which indicated moderate impairment in mental status. The MDS also indicated R15 had almost constant pain that made it hard to sleep at night and limited day-to-day activities. R15 had rated the pain as a 10 however the intensity section of the pain section had not been completed on this MDS. R15's care plan date initiated 1/11/11 and revised on 12/9/11, indicated that R15 had identified pain management needs and	F 309	- This will be completed by 4/10/12. - Audits will be reviewed at QAA x 3 months.		4/10/12

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F 309	Continued From page 7 monitoring needs related to generalized deconditioning (decline), bilateral knee contractures (which R15 was admitted with) due to mild Parkinson ' s disease, seizure disorder and left ulnar neuropathy with a goal to maintain adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain, distress or verbalizing satisfaction with level of comfort. There had been no new pain interventions added to the care plan since 1/11/11. Review of R15 ' s current physician orders dated 1/24/12 revealed that R15 had the following pain medications: neurontin 400 milligram (mg) (used for chronic pain and neuralgia) three times a day, oxycodone hydrochloride 10 mg every day, oxycodone hydrochloride 5 mg every day, oxycodone hydrochloride 5 mg every three hours as prn (needed), Tylenol extra strength 1000 mg three times a day, baclofen 7.5 mg (used for treatment of spasticity) three times a day. The quarterly clinical health status form dated 9/23/11 completed by registered nurse (RN) clinical manager-B indicated R15 had constant, burning, aching, throbbing pain in legs and back with a pain rating of " 7 " on a scale of 1-10. R15 ' s acceptable level of pain was 6. The documentation indicated that the pain impacted quality of life, sleep, functioning and mood. The clinical health status form identified " current pain treatment plan: tylenol, oxycodone, repositioning " " Effective " . The quarterly clinical health status form dated 12/9/11 at 8:00 a.m. completed by registered nurse (RN) -B indicated R15 had constant, sharp pain in left hip and thigh with a pain rating of " 6 " on a scale of 1-10. R15 ' s acceptable level of pain was " 4 " on scale of 0-10. The documentation indicated that the pain impacted	F 309		

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F 309	Continued From page 8 quality of life by limiting activities. The clinical health status form identified " current pain treatment plan: oxycodone, baclofen, sinemet " " Effective " . During review of the medication administration record (MAR) along with the pain monitoring tool, the following was noted concerning R15 ' s use of as needed pain medication: July 2011, R15 had received 7 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 8 to 10. August 2011, R15 had received 13 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 6 to 10. September 2011, R15 had received 3 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 8 to 10. October 2011, R15 had received 13 PRN doses of oxycodone 5 mg for pain rating ranging from 7 to 10. November 2011 it revealed 41 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. December 2011 revealed 38 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. January 2012 revealed 25 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. For the month of February 2012 it revealed 17 PRN doses of oxycodone 5 mg had been given for pain rating ranging from 7-10. Upon review of the effectiveness of the PRN pain medication from July 2011 to March 1, 2012, it was noted that numerous doses of pain medication had not been evaluated for effectiveness. A review of progress notes indicated the following concerns with pain as follows: On 10/20/11 at 9:17 p.m., written by licensed practical nurse (LPN)-A indicated that resident R15 was alert, orientated, and able to communicate her needs to staff ...Resident complained of pain of 8 out of 10. R15 received a	F 309			

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F 309	Continued From page 9 scheduled tylenol and oxycodone. However, there had been no follow up documentation on the effectiveness of these pain medications. On 11/21/11 at 14:51 (2:51 p.m.), written by registered nurse (RN)-D said that R15 received prn oxycodone 5 mg at 10:00 a.m. for pain in legs which had been rated 10 out of 10 (worst pain possible.) Follow up rating was 7 out of 10. On 11/24/11 at 11:39 p.m. written by RN-E said that the resident continued to complain about pain affecting both legs, pain rating at a 9 to 10. This was two hours after the resident received as needed oxycodone. No other interventions or follow up was noted following the complaint of severe pain not being relieved. On 12/1/11 at 10:26 p.m. written by LPN-A said that R15 offered complaints of pain in hip and legs this evening at 9:30 p.m. and received an as needed oxycodone 5 mg. No follow up documentation on the effectiveness of pain medication was documented. On 2/23/12 at 2:21 p.m. written by LPN-B revealed resident was alert and oriented, resident refused shower this shift due to pain and resident rated pain at an 8. LPN-B administered prn oxycodone and it had provided little relief. During an interview on 3/1/12 at 7:11 a.m., RN-C, who worked the night shift, indicated that the previous shift had given R15 pain medication around 9 p.m. the evening before and then RN-C usually gives another as needed pain dose around 4:00 a.m. RN-C stated she had not noticed any changes in pain, just that the pain increased with movement. Staff would offer reassurance, deep breathing and repositioning. R15 usually rated her pain as 8-10. RN-C stated she would go back in R15's room to check on the resident about an hour after prn pain	F 309		

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F 309	Continued From page 10 medication was given and R15 was usually sleeping. RN-C said that R15 was repositioned every 2 hours during the night shift and usually complained of pain during repositioning. During an interview on 3/1/12 at 7:55 a.m., registered nurse clinical manger (RNCM)-A who had worked the day shift, verified that R15 had chronic pain and received pain medication. RNCM-A verified that R15 had an order for oxycodone 10 mg at 6 a.m. and 5 mg at 5 p.m. and an order for oxycodone 5 mg every 3 hours as needed for pain, along with routine tylenol extra strength. RNCM-A confirmed that R15 had been on this combination of medications for quite some time. RNCM-A stated that the licensed nurses would let RNCM-A know of any changes in R15 's pain and prn medication frequency and then she would let the nurse practitioner know. The nurse practitioner would than look for frequently used prn medications and if the pain was controlled with the scheduled medications than may need to adjust times and doses. When asked about the increase in PRN oxycodone medication use from October 2011 to current date (March 1, 2012), the RNCM-A indicated that she was unaware of the frequency of use. RNCM-A felt that R15 's pain was managed as well as it can be managed and that R15 came to the facility with the contractures and chronic pain. On 3/1/12 at 8:42 a.m., a family member (F1) was interviewed and confirmed R15 had experienced a lot of pain and there were times where the pain did go away. F1 indicated that mornings were rough for R15. F1 indicated that pain management had been discussed during quarterly care conferences and it was said that when R15 begins to feel pain she was to put on the call light. F1 indicated that R15 had rated the	F 309			

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F 309	Continued From page 11 pain from 8-10. F1 indicated that they were not aware of any discussion on other options available for pain management for the past several months. F1 discussed bringing up acupuncture as an option for pain relief to the facility and felt it may be a good idea that R15 be reevaluated for pain control. On 3/1/12 at 1:23 p.m., R15 's primary medical doctor (MD) was contacted and verified that R15 had a diagnosis of thoracic neuropathy and felt that pain management had been thoroughly addressed. The MD said that she and the nurse practitioner discussed the resident 's current health conditions, medications R15 currently receives and possible side effects. They had also discussed the possible use of an anti-Parkinson 's medication to help with mobility. When asked about the pain management for R15, MD indicated that she would expect the facility staff to update her if there was a change in R15 's pain so further evaluation could be done. On 3/1/12 at 1:56 p.m., the Director of Nursing (DON) was interviewed and indicated that R15 gets very nervous and anticipatory of pain any time staff want to move her. The DON indicated that staff administers pain medication before moving R15. When questioned about R15 's ongoing use of prn pain medication and lack of monitoring of medication effectiveness since October 2011, the DON said that she would expect the staff to inform the NP to assess the resident 's pain management regimen. The DON indicated the staff needed to complete a comprehensive pain assessment on R15 as soon as possible and have the NP reviews it to evaluate the effectiveness of the pain regimen.	F 309			

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F 309	Continued From page 12 During a telephone interview on 3/2/12 at 8 " 18 a.m., the NP responsible for R15 ' s care, indicated that R15 would never fully get rid of pain and spasms, that she was aware the spasms were worse in the morning and when applying braces on both legs, and indicated the spasms/pain got better throughout the day. The NP indicated R15 received oxycodone before cares were provided and before putting on the leg braces. NP indicated R15 had been seen by her on 1/30/12 and R15 ' s pain management was evaluated and seemed to be the best at this time. NP indicated that there had been no nursing concerns expressed to her in regards to R15 ' s pain management. NP verified she had not been informed by nursing staff of the lack of pain medication effectiveness from October 2011 through February 2012. NP indicated that she evaluated the underlying condition/s for R15 ' s medication regimen especially how they affect the heart and kidney function. NP verified that physical therapy interventions had been attempted over the past year for R15. R49 had bruising that was not identified or monitored. R49 was admitted to the facility on 6/18/10 with diagnoses including cerebral vascular disease with hemiplegia, recurrent thromboembolism, and debility and received anticoagulant medications. On 2/27/12 at 7:19 p.m., R49 had a bruise on outer aspect of left arm above the elbow. R49 was unaware of the bruise and how it had happened.	F 309			

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

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F 309	Continued From page 13 Review of the resident's record did not show any documentation of the bruised area on the left arm. R49's care plan with date initiated 10/25/10 was reviewed and it indicated R49 was at risk for complications related to anticoagulant medication secondary to diagnosis of recurrent thromboembolism and history of CVA (cardio-vascular attack or stroke). Interventions included observe for signs and symptoms of bleeding: tarry stools, blood in urine, bruising, petechiae. On 3/1/12 at 8:36 a.m., registered nurse (RN) clinical manager-B indicated she was unaware of a bruise and verified that there was no documentation regarding a bruise on his arm and that she would go and assess the area at this time. On 3/1/12 at 9:13 a.m., RN-B indicated that when staff identified bruises it was to be reported to the nurse manager and the executive director. Staff perform an investigation, measure the area, document and investigate further to make sure resident was safe. Staff performs a skin inspection weekly and nursing assistants are to let the nurses know if bruises are noted during cares. On 3/1/12 at 1:49 p.m., director of nursing (DON) confirmed the clinical manager would take measurements, talk with resident to ensure no abuse and investigate what happened when a bruise had been identified.	F 309		

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F 309	Continued From page 14 R6 lacked a skin assessment and monitoring of a bruise. R6 was observed at 4:56 p.m., on 2/27/2012, to have bruising on the back of both hands, forearms and finger. Incident reports were reviewed from 12-11-11 to 2-11-12 and no reports identified bruises on the resident. Primary Care Internal Med Nursing Home Limited Exam completed 7/12/11 by the certified nurse practitioner (CNP) indicated R6 had been experiencing an increase in bruising of forearms and hands. Review of quarterly Minimum Data Set (MDS) dated 2/8/12 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and required supervision with locomotion by wheelchair. MDS did not identify concern with bruising. Care plan dated 1/10/12 did not identify risk for bruising with interventions to decrease risk for bruising. During an interview at 11:22 a.m., on 2/29/12, clinical manager (CM)-B stated R6 does always pay attention to where going and gets bruises from hitting hands and arms on things when moving around. CM-B stated there are no incident reports or nursing notes related to bruising on back of R6 's hands and forearms. CM-B indicated the bruising should have been assessed when found and documented. During an interview at 2:40 p.m., on 2/29/12, CM-B stated that she and the CNP believed the	F 309		

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F 309	Continued From page 15 bruising was chronic and related to kidney disease.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure range of motion was provided according to the assessed needs for 2 of 3 residents (R89 and R6) in the sample reviewed for range of motion. Findings include: R89 did not receive range of motion (ROM) services according to their assessed needs. R89 was admitted to the facility on 12/18/08, with diagnoses that included, but were not limited to: Alzheimer disease, dementia with behavioral disturbances and adult failure to thrive. Review of the physician orders revealed that the resident had the following range of motion exercise ordered since 7/2/09: Hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. Review of the restorative documentation record	F 318	F318 - Resident # 6 and #89 have been assessed by therapy and appropriate functional programs have been put in place. - Resident #6 and # 89 have not had any negative effects from this cited deficient practice. - All residents who are assessed as to have limited range of motion deficits have the potential to be effected by this practice. - All residents shall be assessed on admission and near their quarterly ARD by therapy to see if a functional or restorative ROM program is needed. - DNS/ Designee will meet with therapy on a weekly basis to assure new admissions and quarterly reviews are completed. Therapy will train staff on new programs implemented and DNS/Designee will audit to weekly to assure programs are being carried out. - This will be completed by 4/10/12. - Audits will be reviewed at QAA x 3 months.	4/10/12

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F 318	Continued From page 16 for R89 for the month of February 2012 revealed that of 58 opportunities the hamstring stretches were completed "0" zero times. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident ' s refusal. Review of the restorative documentation record for R89 for the month of January 2012 revealed that of 62 opportunities, the hamstring stretches were completed "22" twenty-two opportunities. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident ' s refusal. Review of the restorative documentation record for R89 for the month of December 2011 revealed that of 62 opportunities, the hamstring stretches were completed "24" twenty-four opportunities. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident ' s refusal. During interview with the Registered Nurse Clinical Manager-A on 2/29/12, at 9:53 a.m. She confirmed that the resident should be having hamstring stretch with feet up on chair/lowered bed for 5-10 minutes offered twice a day. She confirmed that the rehab program was not consistently implemented and the nursing assistant assigned to the residents care should have written an explanation of why the range of motion exercise or reasons for refusal on the restorative record if the range of motion exercise was not completed.	F 318			

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F 318	Continued From page 17 Resident (R6) lacked development of restorative nursing/range of motion per physical therapy recommendation. R6 was admitted on 6/15/2010, with diagnoses that included but are not limited to history of stroke, history of hip fracture and joint replacement and osteoarthritis. At 11:47 a.m., on 2/29/12, R6 was observed during a transfer from a sitting position to a standing position. R6 was observed to perform a pivot transfer with assist of staff. R6 knees were bent and together. Hinged brace was in place on left knee. Interview with R6 at 4:43 p.m., on 2/27/12 and R6 stated she needed staff assistance to get in and out of bed. Review of quarterly Minimum Data Set (MDS) dated 2/8/12, revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene. MDS did not indicate use of restorative nursing programs. Care plan print date of 1/10/12, lacked care plan interventions for range of motion/restorative nursing. Rehab Recommendations dated 9/8/11 included hamstring stretches twice a day after each meal. Rehab Recommendations dated 1/27/12, included " after each meal, lower the bed, put feet up to stretch hamstrings/knees. Remind [R6] to relax and push knees straight 10-15 [times]. " Physical therapy program coordinator was interviewed at 3:21 p.m., on 2/29/12 and indicated	F 318			

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F 318	Continued From page 18 therapy sets up restorative programs. Physical therapy program coordinator stated R6 was discharged from therapy on 2/24/11 and was to continue with restorative exercises. She indicated procedure was for therapy to hand over the restorative program to the clinical managers. Restorative Guideline procedure (undated) was reviewed. Restorative nurse coordinator with input from therapy makes resident selections. Restorative coordinator initiates the restorative nursing worksheet and restorative nursing staff document on the worksheet. Restorative nursing worksheets for December 2011, January 2012 and February 2012 did not identify therapy recommendations for hamstring stretches. During an interview on 3/1/12, 9:15 a.m., with clinical manager (CM)-B, CM-B indicated she was in charge of the restorative program on second floor and stated she has not been monitoring for compliance. CM-B verified documentation of restorative program for R6 was not completed consistently. CM-B verified the hamstring program was not included in the restorative program as recommended by physical therapy. CM-B stated she received education on 3/1/12 from a clinical consultant on restorative programs. CM-B stated she plans to start monitoring the restorative program for compliance and effectiveness.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 19 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the safe use of side rails for 3 of 3 residents (R14, R6, and R117) reviewed in the sample that used side rails. Findings include: R14, who utilized 2-1/2 side rails, was not assessed as safe to use side rails that had an opening of 12.5 inches from the head of bed to the edge of the side rail and the same side rails were very loose when touched. During observations on 2/27/12, at 4:53 p.m., 2-1/2 side rails were observed in the up position. Observation at that time revealed a large space between the top of rails and the head of bed. Observation revealed the 2 side rails were loose and wobbly in all directions when surveyor hand placed on the rails. During interview at that time, R14 stated the side rails were used for positioning. During observations on 2/29/12, at 2:00 p.m., 2-1/2 side rails were observed in the up position. Observations at that time revealed the opening from the head of the bed to the edge of the side rails measured 12.5 inches. Observations revealed the 2 side rails were loose and wobbly in all directions when surveyor placed hand on rails.	F 323	• F323 • Resident # 14, 6, and 1 have had their beds replaced and a new side rail assessments completed. 117 has had side rail removed. • No injuries or accidents have occurred with current SR assessments in place. • All residents at the facility who use a SR have the potential to be effected by this practice. • FDA guidelines have been reviewed and are utilized for ensuring safety of all residents. • All resident in facility who have been assessed to have SR used will have there assessments updated quarterly, annually and with a change of condition. • DNS/Designees will audit resident with SR to assure that the assessment is being completed quarterly. Any deficient practice shall be corrected at time of audit. • Maintenance has a system for reviewing loose rails through Building Engines. • This will be completed by 4/10/2012. • Audit findings shall be reviewed at QAA x 3 months.		4/10/12

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F 323	Continued From page 20 R14 was admitted 2/18/04, with diagnosis that included Cohen 's disease and cerebral palsy. The facility identified R14 on the annual Minimum Data Set (MDS), an assessment dated 7/11/11, to be cognitively intact, no moods, no behaviors, required extensive assistance of 1 staff for activities of daily living which included bed mobility and transfers, identified with physical limitations of weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain, and no physical restraints were used. Document review of physician orders dated 9/8/10, revealed orders for bilateral upper side rails to help maintain functional mobility and assist with repositioning needs. Document review of incident reports for the past 3 months, revealed no incidents related to side rail use. Document review of the facility fall risk assessment dated 1/11/12; identified R14 was at risk for falls. Document review of the facility quarterly nursing review dated 1/11/12, identified R14 used side rails and that the side rail assessment was done. Document review of the facility side rail assessment dated 5/6/10, and reviewed quarterly dated 1/11/12, identified side rails were not a restraint and side rails were used for positioning and support. The side rail assessment identified the side rail had been measured and the gaps between the rails themselves and the gaps	F 323			

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F 323	Continued From page 21 between the side rail and the mattress were conducive to resident safety as based on this individual resident. The side rail assessment identified the head of the bed was elevated to conduct a visual review to assess the mattress and the side rail did not have a gap large enough to impose a resident safety issue/concern based on this individual resident. The side rail assessment identified a visual review was performed to assess that the mattress did not shift between the bed and side rail and concluded there were no safety issues. Document review of the resident care plan dated 7/20/11, directed staff R14 was at risk for falls and had mobility impairment. Resident care interventions included bed mobility assistance of side rail and 1 staff and turning and positioning program every 2 hours with assist of 1 staff and side rail. Document review of nursing progress notes dated 1/11/12; revealed R14 was independent with bed mobility with the use of 2 upper side rails for positioning needs. During interview on 2/29/12, at 2:05 p.m., nursing assistant-D (NA-D) stated not aware of any incidents that involved side rails. During interview on 2/29/12, at 2:10 p.m., clinical manager-B (CM-B) verified the large gap between the head of the bed and end of the side rails, a distance of 12.5 inches. During interview on 2/29/12, at 2:43 p.m., CM-B stated R14 had no incidents or falls related to side rails. During interview on 3/1/12, at 7:20 a.m., NA-D	F 323			

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F 323	Continued From page 22 verified R14 used the side rails for turning and assisting with transfers. During interview on 3/1/12, at 1:00 p.m., registered nurse-A (RN-A) verified the side rails which were in the up position, were loose and wobbly on R14 's bed. During interview on 3/1/12, at 6:43 a.m., clinical manager-B (CM-B) stated the facility procedure for side rail assessment included clinical managers conducted the clinical aspect of the side rail assessment and maintenance measured the side rails for safety. CM-B stated the clinical managers assessed the safety of residents with side rails and would side rails improve the independence of the resident. CM-B stated the maintenance director used a tool to measure safety of side rails to the bed. During interview on 3/1/12, at 6:50 a.m., the maintenance director stated he measured side rail openings between the bars and measured the distance from the side rails to the mattress. The maintenance director stated he measured side rail safety with a test kit. He verified he did not assess the opening between the head of the bed and the end of the side rail. During interview on 3/1/12, at 1:30 p.m., maintenance assistant verified the sides rails were loose and stated the side rails were as tight as they could be. R6 lacked comprehensive assessment for safe use of side rails and lacked side rails that were secure.	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 23 R6 was observed on 02/27/2012, 4:58:28 p.m., and the ½ side rails on both sides of the bed were in the up position. During interview with resident at 4:43 p.m. on 2/27/12, R 6 stated the side rails were used to move in bed. R6 was admitted on 6/15/2010 and had diagnoses that included but not limited to mild cognitive impairment, depression, history of stroke and mild mental retardation. Review of annual Minimum Data Set (MDS) dated 5/26/2011 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and does not identify the use of a side rail as a restraint. Review of quarterly MDS dated 2/8/12 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and did not identify the use of a side rail as a restraint. Physician order dated 6/15/10 indicated R6 was to have bilateral upper side rails to maintain functional mobility and assist with repositioning. Physician order dated 11/18/11, indicated resident was to have two 1/3 tops side rails for repositioning. Physician order dated 11/21/11, indicated R6 was to have two 1/3 grab bars to aid in mobility. The facility's Side Rail Assessment Screen dated 11/17/11, indicated side rails were used as assistive devices and R6 is unable to get in and out of bed independently. Side Rail Assessment Screen indicated the side rail has been measured and the gaps between the rail(s) themselves and the gaps between the side rail and the mattress	F 323			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904
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F 323	Continued From page 24 are conducive to resident safety as based on this individual resident and the head of the bed was elevated to conduct a visual review to assess that the mattress and the side rail did not have a gap large enough to impose a resident safety issue/concern based on this individual resident. The Side Rail Assessment Screen did not evaluate all areas identified by the U.S. Department of Health and Human Services Food and Drug Administration (FDA). The side rail assessment screen lacked potential entrapment risk of zone 6, entrapment between the end of the rail and the side edge of the head or foot board. During interview on 3/1/12, at 6:43 a.m., clinical manager-B (CM-B) stated the facility procedure for side rail assessment included clinical managers conducted the clinical aspect of the side rail assessment and maintenance measured the side rails for safety. CM-B stated the clinical managers assessed the safety of residents with side rails and would side rails improve the independence of the resident. CM-B stated the maintenance director used a tool to measure safety of side rails to the bed. During interview on 3/1/12, at 6:50 a.m., the maintenance director stated he measured side rail openings between the bars and measured the distance from the side rails to the mattress. The maintenance director stated he measured side rail safety with a test kit. He verified he did not assess the opening between the head of the bed and the end of the side rail. In addition R6 had side rails that were wobbly and not secure.	F 323		
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
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F 323	Continued From page 25 R6 was observed on 02/27/2012, 4:58:28 p.m., and the ½ side rails on both sides of the bed were in the up position and the room side bed rail was wobbly. During interview with resident at 4:43 p.m. on 2/27/12, R 6 stated the side rails were used to move in bed. In addition R6 had side rails that were wobbly and not secure. Review of care plan with print date 1/10/12, indicated R6 required use of side rails when in bed related to need for assist with bed mobility, R6 was to use 2 1/3 rails when in bed to aide with bed mobility, complete side rail assessment quarterly and update quarterly During an interview with clinical manager (CM)-B, in resident room at 11:50 a.m. on 2/29/12, verified side rail was wobbly on room side of the bed and stated she would contact maintenance to fix the side rail right away. During an interview with nursing assistant (NA)-C, in resident room at 11:52 a.m. on 2/29/12, verified side rail was wobbly and stated the side rail was new three weeks ago as the previous side rail was broken by the lift. R6 confirmed. During an interview with Maintenance Director at 7:17 a.m. on 3/1/12, he indicated he was unaware the side rail on R6 ' s bed was in need of repair. The maintenance director explained the procedure was for staff to report needed repairs on the computer system. He then stated he would go to the room of R6 and check the side rail. R6 ' s side rail was replaced.	F 323			

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F 323	Continued From page 26 R1 lacked safe and secure side rails. During observation at 9:08 a.m., on 3/1/12, the side rail on room side of bed was wobbly and the side rail by the window was cracked. NA-B was present in the resident room and verified side rail was wobbly and cracked. NA-B stated she would report it. R1 was admitted to the facility 6/17/2010. R1 had physician orders dated 11/15/11 for 2 1/3 grab bars to aid in bed mobility. The facilities Side Rail Assessment Screen dated 7/21/11; indicated R1 utilized side rails to enable the resident maintain highest level. At 9:12 a.m. on 3/1/12, CM-B stated she was unaware of the wobbly and cracked side rails on R1 's bed and stated she would report it immediately to be fixed. CM-B stated she had not checked the side rails on the unit to see if any were wobbly or cracked. R117 was not comprehensively assessed for safe use of side rails on the bed. R117 was admitted on 3/31/2011 with diagnosis which included Parkinson's disease, bipolar disorder, depressive disorder, cervical myelopathy and insomnia. On 2/28/2011 at 1:30 p.m., R117 was observed in bed sleeping with 2 -1/2 side rails in the up position. On 2/29/2012 at 8:48 a.m., R117's side rails were	F 323			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904
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F 323	Continued From page 27 in the up position. They were measured at 4 inches in the open areas and 12.5 inches from the headboard to the side rail. On 2/27/2012 at 5:08 p.m., Clinical Manager (CM)-A was interviewed. She indicated R117 used 2-1/2 side rails on the bed for positioning and was capable of getting out of bed on own. According to the side rail assessment screen dated 3/31/2011, R117 was assessed as having short and long term memory loss with moderate cognitive impairment and had periods of altered perception. The side rail assessment identified the side rail had been measured and the gaps between the rails themselves and the gaps between the side rail and the mattress were conducive to resident safety as based on this individual resident. The side rail assessment identified the head of the bed was elevated to conduct a visual review to assess the mattress and the side rail did not have a gap large enough to impose a resident safety issue/concern based on this individual resident. The side rail assessment identified a visual review was performed to assess that the mattress did not shift between the bed and side rail and concluded there were no safety issues. Incident reports dated 11/10/11, 11/17/11, and 1/28/2012 identified the resident as self-transferring out of bed or found on the floor from bed. An initial Minimum Data Set Assessment (MDS) dated 4/7/2011 was reviewed. The resident was identified as cognitively alert and oriented. R117 required extensive assist of one staff for bed	F 323		

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

**501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904**

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F 323	Continued From page 28 mobility, transfer, and ambulating in room and corridor. Subsequent quarterly MDS assessments dated 7/5/2011, 9/30/2011, and 11/27/2011 was reviewed and identified the same cognitive status. However, they identified bed rails were not used. On 3/1/2012 at 8:30 a.m., clinical manager (CM) -A verified the resident had side rails on her bed since admission on 3/31/2011. During interview on 3/1/12, at 6:50 a.m., the maintenance director stated he measured side rail openings between the bars and measured the distance from the side rails to the mattress. The maintenance director stated he measured side rail safety with a test kit. He verified he did not assess the opening between the head of the bed and the end of the side rail. Document review of the facility side rails guideline policy revised dated 1/11, directed staff the purpose of the side rail utilization included to aid in turning and repositioning while in bed and to provide a hand-hold for getting in or out of bed. The facility policy directed the assessment was completed to identify potential benefits from utilizing side rails and minimize risks. The facility policy directed "The assessment and documentation also includes: measuring the gaps between the rail(s) themselves and the gaps between the side-rail and the mattress. A visual review is performed to assess that the mattress does not shift/slide allowing for an increased gap between the bed and the side rail."	F 323		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
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F 329	Continued From page 29 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate monitoring for effectiveness of narcotic usage for 1 of 1 resident (R15), adequate indications for anti-depressant medication for insomnia for 1 of 1 resident (R117) and lacked laboratory tests for anti-cholesterol medications for 1 of 10 residents (R6) in the sample. Findings include: R15 received oxycodone (a narcotic pain	F 329	F329 - Resident # 15 has had a new pain assessment. Resident # 6 has had anti-cholesterol medication discontinued. Resident # 117 is on Trazadone and a sleep diary has been put out to monitor sleep patterns - Residents cited in this practice have not had ill effects due to cited deficient practice. - All residents in facility on these medications have the potential to be effected by this cited deficient practice. - DNS/Designee will audit all residents on a hypnotic to assure they have a sleep monitoring diary completed in last quarter and if none found will complete one. All blood glucose monitoring will be reviewed to assure they have Parameters in place as to when to notify MD/NP. Licensed Nurses shall receive education on notifying NP/MD blood sugars outside of parameters. - This will be correct by 4/10/12. - Results of audits and corrections will be reviewed at QAA x3 months.	4/10/12

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

501 EIGHTH AVENUE SOUTHEAST

ROCHESTER, MN 55904

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Continued From page 30
medication), but lacked monitoring of the effectiveness of the medication.

R15, admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's disease, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a physician's order for oxycodone hydrochloride 5 mg every three hours prn (as needed) for pain. Review of the medication administration record (MAR) revealed that resident had received oxycodone 5 mg every three hours prn for pain. The documentation was not completed for the effectiveness of the pain medication. Review of November 2011 MAR revealed that R15 had received oxycodone prn 41 times and had follow-up documentation only 26 times and included pain rating only 5 times in follow up documentation. Review of December 2011 MAR revealed that R15 had received oxycodone prn 38 times and had follow-up documentation 20 times, but included pain rating only 3 times. Review of January 2012 MAR revealed that R15 had received oxycodone prn 25 times with follow-up documentation done 16 times, but included pain rating 1 time. Did not receive prn sheet for the month of February that was requested on 3/1/12 and 3/2/12. Review of MAR revealed that R15 had an increased usage of oxycodone since November 2011. On 3/1/12 at 7:55 a.m., RN clinical manager-B verified that R15 had chronic pain and received pain medication. RN clinical manager verified that R15 had an order for oxycodone 5 mg every 3 hours as needed for pain. RN clinical manager revealed that the licensed nurses would let the

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

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RN clinical manager know of any changes in pain and prn frequency and then would let the nurse practitioner know to review. The nurse practitioner would then look for frequently used prn medications and if the pain was controlled with the scheduled medications than may need to adjust times and doses. RN clinical manager indicated that she was unaware of any changes in the amount of prn usage for the past few months for R15. RN clinical manager felt that R15's pain was managed as well as it can be managed. On 3/1/12 at 1:56 p.m., Director of Nursing (DON) was interviewed and indicated that R15 gets very nervous and anticipatory of pain any time staff want to move her. DON would expect the staff to take the information to the NP if using excessive prn medications and would bump up the medication to something more effective. DON verified that the staff need to get another pain assessment done and into the NP as soon as possible.

R117 received trazodone (an antidepressant used as a sleeping aid) for insomnia without adequate indications.

A review of documents revealed the physician ordered trazodone 50 mg. orally at bed time for insomnia on 4/11/2011. The physician ordered increases to the medication up to 200 mg at bedtime and then on 10/19/2011, the physician ordered a decrease to 100 mg orally at bed time. R117 was currently receiving the 100 mg dose at bedtime.

A physician note dated 4/11/2011 was reviewed. It noted "patient has a main complaint to me today of insomnia. " "Would like to start a low dose of trazodone"

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
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F 329	Continued From page 32 On 2/29/2012 at 11:30 a.m., Clinical Manager (CM)-A was interviewed. She indicated the resident was admitted on 3/31/2011 and the trazodone medication initially was started on 4/11/2011, increased several times and then decreased to 100 mg for insomnia. The CM verified a sleep assessment should have been done initially but it had not been done. The facility policy and procedure for Sleep Problems, undated, indicated the team needed to assess the resident's routine and customary habits to determine if the sleep disturbance was a problem. R6 lacked blood laboratory results for use of anti-cholesterol medications and diabetes management and Certified Nurse Practitioner (CNP) notification of blood glucose levels out of identified range. R6 was admitted to the facility on 6/15/2010 and had diagnosis that included but not limited to: hypoglycemia, chronic kidney disease, diabetes. R6 had physician orders dated 6/15/10 for Simvastatin 10 mg at bedtime for high lipid levels. Insulin NPH 20 units ordered 5/9/11 for diabetes management. Reviewed laboratory results identified in clinical record dated 7/18/11 and laboratory results lacked monitoring of cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). On 3/1/12, at 12:45 p.m. clinical manager (CM)-B was interviewed and indicated medication	F 329			

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F 329	Continued From page 33 procedure was to obtain laboratory results twice a year. She indicated that she was unable to find cholesterol results. Physician order dated 11/20/11 directed staff to test the resident 's blood glucose levels twice daily and to notify the CNP if blood glucose levels were less than 100 or greater than 150. Review of medication administration record (MAR) for R6 revealed in February 2012 R6 experienced blood glucose levels in excess of 150 for periods of three to six consecutive days three times during the month and these had not been reported to the CNP. On 3/1/12, at 12:45 p.m. CM-B verified CNP was not notified of elevated glucose levels.	F 329			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to reassess oral health status and provide dental services for 1 of 1 resident (R132) in the sample who had	F 412	• F412 • Resident # 132 had his 3/13/12 scheduled dental appointment moved to 3/1/12 to have his oral concern taken care of. • NP had seen resident on onset of c/o pain and it was felt he could wait until the scheduled dental appointment on 3/13/12. Resident demonstrated normal ADL pattern and meal consumption and had no adverse effects from not seeing dentist when he made initial concern of oral pain.		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 412	Continued From page 34 complaints of tooth pain. Findings include: R132 voiced complaints of multiple tooth pain that had not been assessed and dental services had not been provided timely. R132 was observed on 2/28/12 at 9:17 a.m. during which it was noted that the resident had multiple broken and carious teeth. It was noted that a thick layer of white debris coated the resident's teeth. During interview with the resident at that time he stated that he had pain in his teeth. Review of the nursing progress notes for the month of February 2012 revealed that there were no comments or assessment of oral status or tooth pain for R132. Registered Nurse (RN) Clinical Manager B was interviewed on 3/1/12 at 8:20 a.m. during which she confirmed that the resident had complained of tooth pain the previous week she confirmed that the residents medical record did not contain comments or assessment of oral status or tooth pain for R132. RN clinical manager B did state that she notified the nurse practitioner of the issue but the resident's record did not contain any evidence that the nurse practitioner had addressed the concern. RN clinical manager B provided documentation of a nurse practitioner visit entered on 3/1/12, at 1:12 p.m. that identified the following: "2/24/12, [RN clinical manager B] informs me that pt had c/o tooth ache to tablemate. Pt has missing teeth, no drainage, no redness, no swelling, no fever. Pt is eating and drinking without difficulty. Pain	F 412	- All resident at facility may be effected by this cited deficient practice. - Residents oral needs will be reviewed at admission, quarterly and on a prh basis for dental care needs. - Nurses will receive education to contact SS if a resident has complaints of oral pain. - DNS/Designee will audit new admissions and quarterly screened to see if dental care is needed and refer to SS. - This will be completed by 4/10/12. - Audit results shall be brought to QAA x3 months.	4/10/12	

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

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 412

Continued From page 35
apparently is intermittent on the right side, but is
unable to pinpoint or c/o any pain when asked.
advised nonemergent dental appt. notify me of
any increase in [symptoms] esp [especially]
swelling..."

Review of the care plan (unable to find date in
electronic medical record) the following
interventions were identified related to dental:
Assistance with oral care as needed. Inspect oral
cavity for bleeding of gums or other issues.
Medication and or treatment as ordered. Refer for
Dental services as needed.

F 412

Further interview with Registered Nurse (RN)
Clinical Manager B was interviewed on 3/1/12, at
8:20 a.m. she stated that she put the resident on
the list for a dental exam for the next time the
contracted dental services were coming to the
facility but did not know when that would be. The
clinical manager then called the director of
nursing and asked her when the dental company
who provides the facility with routine dental
services was coming to the building and she
stated that she did not know and that they would
get back to me. The director of nurses came back
on 3/1/12 at approximately 8:45 a.m. and stated
that the contracted dental services were not
scheduled to come to the facility for routine dental
care until 3/13/12 (18 days after the resident
complained of tooth pain.)

F 428

F 428
SS=D

483.60(c) DRUG REGIMEN REVIEW, REPORT
IRREGULAR, ACT ON

The drug regimen of each resident must be
reviewed at least once a month by a licensed
pharmacist.

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

RECEIVED

PRINTED: 03/29/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Minn Dept of Health Rochester Office		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page 36 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility consultant pharmacist failed to identify irregularities and report them to the physician and director of nursing concerning adequate monitoring for effectiveness of narcotic usage for 1 of 1 resident (R15), adequate indications for anti-depressant medication for insomnia for 1 of 1 resident (R117) and lacked laboratory tests for anti-cholesterol medications for 1 of 10 residents (R6). Findings include: R15 received received oxycodone (a narcotic pain medication), but lacked monitoring of the effectiveness of the medication. R15, admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a physician's order for oxycodone hydrochloride 5 mg every three hours as prn (needed) for pain. Review of the medication administration record (MAR) revealed that resident had received oxycodone 5 mg every three hours prn for pain. The documentation was not completed for the effectiveness of the pa in medication. Review of	F 428	• F428 R15 • Resident # 6 anti-cholesterol medication has been discontinued The NP was notified related to blood glucose levels. Resident # 117 is on a hypnotic and a sleep diary has been put out to monitor sleep patterns Resident #15 has had a new pain assessment completed. • Residents cited in this practice have not had ill effects due to cited deficient practice. • All residents in facility on these medications have the potential to be effected by this cited deficient practice. • DNS/Designee will audit all residents on a hypnotic to assure they have a sleep monitoring diary completed in last quarter and if none found will complete one. All blood glucose monitoring will be reviewed to assure they have Parameters in place as to when to notify MD/NP. Consultant pharmacist was notified of this deficient practice and received education on 3-13-12 and instructed on need to get pharmacy reports to DNS to correct any recommendations.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page 37 November MAR revealed that R15 had received oxycodone prn 41 times and had follow-up documentation 26 times, but included pain rating only 5 times in follow up documentation. Review of December MAR revealed that R15 had received oxycodone prn 38 times and had follow-up documentation 20 times, but included pain rating only 3 times. Review of January MAR revealed that R15 had received oxycodone prn 25 times with follow-up documentation done 16 times, but included pain rating 1 time. Did not receive prn sheet for the month of February that was requested on 3/1/12 and 3/2/12. Review of MAR revealed that R15 had an increased usage of oxycodone since November. On 3/1/12 at 1:02 p.m., interview with pharmacy consultant revealed that the increase in oxycodone was not addressed. Pharmacy consultant indicated that he would not be concerned about the increase in prn pain medication but would be concerned about constipation and fall side effects. He indicated that he did not feel the lack of identification of the increased prn pain medication was a big deal. R117 was on trazodone medication used as a sleep aid for insomnia. No sleep assessment to identify patterns or routine of sleep was completed prior to initiation of the sleep aid medication. According to physician orders dated 10/19/2011, R117 was receiving Trazodone 100 mg. at bedtime for insomnia. Pharmacy reviews dated 4/28/2011 through 2/2012 were reviewed. The pharmacy reviews addressed the use of trazedone but did not address the need for a	F 428	- This will be corrected by 4-10-12. - Results of audits and corrections will be reviewed at QAA x3 months.		4/10/12

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

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

**501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 38 sleep assessment. On 2/29/2012 at 11:30 a.m., Clinical Manager (CM)-A was interviewed. She indicated the resident was admitted on 3/31/2011 and the trazodone medication initially was started on 4/11/2011, increased several times, and then decreased to 100 mg. for insomnia. The CM verified a sleep assessment should have been done initially but it had not been done. R6 lacked consultant pharmacist identification of irregularities related to laboratory results and diabetes management. R6 was admitted to the facility on 6/15/2010 and had diagnosis that included but not limited to: hypoglycemia, chronic kidney disease, diabetes. R6 had physician orders dated 6/15/10 for Simvastatin 10 mg at bedtime for high lipid levels. Insulin NPH 20 units ordered 5/9/11 for diabetes management but lacked laboratory results monitoring cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). Physician order dated 11/20/11 directed staff to test the resident's blood glucose levels twice daily and to notify the CNP if blood glucose levels were less than 100 or greater than 150. Review of medication administration record (MAR) for R6 revealed in February 2012 R6 experienced blood glucose levels in excess of 150 for periods of three to six consecutive days three times during the month. Reviewed laboratory results identified in clinical	F 428		

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

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

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F 428	Continued From page 39 record dated 7/18/11 and laboratory results lacked monitoring of cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). On 3/1/12, at 12:45 p.m., clinical nurse manager -B was interviewed and indicated medication procedure was to obtain laboratory results twice a year. She indicated that she was unable to find cholesterol results and verified CNP was not notified of elevated glucose levels. The consultant pharmacist (CP) was interviewed by telephone at 3:10 p.m., on 3/2/12. CP stated a baseline liver functioning test is completed one time and recommends every six months after. CP stated cholesterol panel guideline is for completion of a cholesterol panel yearly and stated again he recommends every six months. CP stated A1C was not needed for blood glucose monitoring. He stated he reviews blood sugars and makes recommendations as needed.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 40 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to maintain an infection control program that would analyze infection trends and patterns of infections in the facility in order to prevent, recognize, and control the spread of infection. This had the potential to affect all 102 of 102 residents in the facility. Findings include: The facility's " Line Listing of Resident Infection " surveillance forms were reviewed for October, November and December 2011. The surveillance sheets was to include the following information: resident name, room number and unit, admission	F 441	• F441 • No residents have been found to be effected by this cited deficient practice. • All residents at facility have the potential to be effected by this cited deficient practice. • Facility IC nurse received education on line listing and tracking and trending infections on 4/2/12. • DNS/Designee shall audit IC logs weekly to assure that tracking and trending is taking place. • This will be corrected by 4/10/12. • Results of audits shall be reviewed at QAA x 3 months to assure proper tracking and trending with infection control is occurring.	4/10/12	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ APR 4 2012 B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE
501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 41 date, type of infection, date and onset of symptoms, cultures (including date done, site and result), treatment to include type of medication and when the infection was resolved, and whether or not an infection is nosocomial (infections that develop as a result of a stay in hospital.) The infection control surveillance forms were consistently not completed in an organized, legible and systematic manner and revealed the following: October 2011: 24 out of 25 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. November 2011: 10 out of 12 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. December 2011: 22 out of 22 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. On 3/1/2012, at 1:21 p.m. the Infection Control Nurse (ICN) was interviewed and confirmed the "Line Listing of Resident Infections" forms were not complete with the information to aide in analysis and tracking of resident infections. The ICN confirmed there was a lack of consistency related to data collection and analysis of the information. On 3/1/2012, at 3:00 p.m. the director of nursing	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ROCHESTER EAST

STREET ADDRESS, CITY, STATE, ZIP CODE

501 EIGHTH AVENUE SOUTHEAST
ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 42 (DON) was interviewed regarding the infection control program. The DON stated the program "was not where it needs to be" because the ICN was also responsible for hiring new employees and that was more of a priority. The facility's policy/procedure titled " Introduction Infection Control in Long-Term, Care " dated 2001 with a revision date of October 2011. The policy indicated that the infection control program should have components to include employee health, environmental infection control, and surveillance and reporting, managing the infection control aspects of various clinical conditions, and immunization and vaccination.	F 441		

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

F5184021

Printed: 03/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - Rochester East was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Golden Livingcenter - Rochester East, is a 3-story building with a full basement. The facility was built in 1968 and was determined to be of Type II(222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 102 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000			

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

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

REVISED

Certified Mail # 7010 2780 0001 4939 7220

March 28, 2012

Ms. Carey Huebert, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Re: Enclosed State Nursing Home Licensing Orders - Project Number

Dear Ms. Huebert:

The enclosed State Form has been revised. This letter and State Form replaces our previous letter and State form dated March 21, 2012.

The above facility was surveyed on February 27, 2012 through March 1, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

Golden LivingCenter - Rochester East

March 28, 2012

Page 2

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. 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 me.

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,



Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2731

Enclosure(s)

cc: Original - Facility
Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7152

March 21, 2012

Ms. Carey Huebert, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5184024

Dear Ms. Huebert:

The above facility was surveyed on February 27, 2012 through March 1, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Golden LivingCenter - Rochester East

March 21, 2012

Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. 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 me.

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,



Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5184s12lic.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00953	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(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	
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 27, 28, 29, March 1, 2012 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.		

Minnesota Department of Health

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

STATE FORM

TITLE

Executive Director

(X6) DATE

4/4/12

Minnesota Department of Health

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2 000	Continued From page 1 Licensing and Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately reassess pain management for 1 of 1 resident (R15) in the	2 550			

Minnesota Department of Health

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FORM APPROVED

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2 550	Continued From page 2 sample that experience chronic pain. Findings include: R15 had an increase in use of as needed pain medication from October 2011 to March 1, 2012 and did not have a pain reassessment completed to evaluate the pain regimen for optimal pain control. During an interview and observation on 2/27/12, at 4:27 p.m., R15 was lying in bed on her back holding the trapeze with her right hand and R15 verbalized pain mostly in left leg with no relief. During the interview with R15 she would hang on to the trapeze and grimace. R15 then said that there were painful spasms occur every 15 minutes which were not new and have been present for some time now. The quarterly Minimum Data Set (MDS) dated 12/8/11 was reviewed and compared with the quarterly MDS dated 9/12/11. The MDSs indicated R15 was clearly able to express ideas and wants; mild depression and no behaviors. The 12/8/11 MDS pain interview indicated R15 experienced almost constant pain that limited day to day activity, made it hard to sleep at night, and rated the pain at a "10" on a scale of 0-10, 10 as the worst pain imaginable. This was an increase in pain since 9/6/11. The comprehensive quarterly review dated 12/9/11 for the quarterly MDS indicated R15 had daily pain due to bilateral leg contractures and spasticity. On 3/1/12 at 1:56 p.m., the director of nursing verified that R15's pain should have been looked into and adjusted medications to be more effective. R15 needed another pain assessment completed. SUGGESTED METHOD OF CORRECTION: The administrator and the director of nursing (DON) or her designee could develop policies and	2 550			

Minnesota Department of Health

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2 550	Continued From page 3 procedures to ensure comprehensive assessments are completed at the time of the quarterly MDS. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to develop care plan interventions that included restorative nursing for 1 of 3 residents (R89) in the sample reviewed for range of motion and the facility failed to develop interventions for residents at risk for bruising for 1 of 3 residents (R6) in the sample who had bruising. Findings include: R89 had range of motion (ROM) ordered by the physician however, the care plan did not have any ROM interventions or directions to be followed by staff.	2 560		

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2 560	Continued From page 4 R89 was admitted to the facility on 12/18/08, with diagnoses that included, but were not limited to: Alzheimer ' s disease, dementia with behavioral disturbances and adult failure to thrive. Review of the physician orders revealed that the resident had the following range of motion exercise ordered since 7/2/09: Hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. Review of the residents current care plan dated 11/4/11, revealed that there was no care plan that identified the resident should have hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. During interview with the Registered Nurse Clinical Manager-A on 2/29/12, at 9:53 a.m. she confirmed that care plan interventions for the resident range of motion had not been developed. R6 was at risk to develop bruises and R6's care plan did not address this concern. R6 was observed at 4:56 p.m., on 2/27/2012, to have bruising on the back of both hands, forearms and finger. Primary Care Internal Med Nursing Home Limited Exam completed 7/12/11 by the certified nurse practitioner (CNP) indicated R6 had been experiencing an increase in bruising of forearms and hands. Review of quarterly Minimum Data Set (MDS) dated 2/8/12 revealed moderate cognitive	2 560			

APR 4 2012

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Minn Dept of Health
Rochester Office

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2 560	Continued From page 5 impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and required supervision with locomotion by wheelchair. MDS did not identify concern with bruising. Care plan dated 1/10/12 did not identify risk for bruising with interventions to decrease risk for bruising. During an interview at 11:22 a.m., on 2/29/12, clinical manager (CM)-B stated R6 does always pay attention to where going and gets bruises from hitting hands and arms on things when moving around. CM-B stated there are no incident reports or nursing notes related to bruising on back of R6 's hands and forearms. CM-B indicated the bruising should have been assessed when found and documented. During an interview at 2:40 p.m., on 2/29/12, CM-B stated that she and the CNP believed the bruising was chronic and related to kidney disease. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	2 830			

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2 830	Continued From page 6 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate care and services for pain management for 1 of 3 residents (R15) in the sample reviewed for chronic pain. This resulted in actual harm to the resident. Additionally, The facility failed to comprehensively assess skin bruises for 2 of 3 residents (R49 and R6) in the sample who had skin conditions that were not pressure related. Findings include: R15 had ongoing chronic pain/spasms without consistent monitoring of the effectiveness of the pain medication, demonstrated an increase in pain intensity and fluctuating frequency of as needed (PRN) pain medication use for the past five months without a pain reassessment to determine optimal pain control for R15. R15 was admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a history of ongoing chronic pain rated at a 6 to 8 on a scale of 1 to 10, with 10 being the worst	2 830			

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2 830	Continued From page 7 pain. During observations on 2/27/12, at 4:27 p.m. R15 was lying in bed on her back holding the trapeze with her right hand and grimacing at times. R15 verbalized pain mostly in left leg with no relief. During an interview at this time R15 said that she was having left leg spasms that occurred about every 15 minutes. R15 continued to say that the spasms have been occurring for months but have gotten worse lately and the pain medication did not always relieve the pain. During observation on 2/29/12 at 11:54 a.m. nursing assistant (NA)-B and NA-E were going to get R15 up for lunch and R15 requested to stay in bed due to having the diarrhea. During an interview at this time R15 indicated she was having pain and rated it at a 10/10. NA-B said that she would let licensed practical nurse (LPN) -B know about the pain. As NA-A lifted R15 in bed R15 began to crying and say "ouch" 6 times while being repositioned. R15 continued to cry out "ouch, oh my god". While NA-B and NA-E provided perineal care, R15 said "ouch" "oh my god" several times. On interview R15 complained of her leg hurting. NA-E then told R15 that the nurse would be bringing in her "oxy" (oxycodone) a pain medication. During an interview with NA-B following R15's cares at 12:11 p.m. it was learned that R15 typically complained of pain during cares. During observation on 3/1/12 at 7:18 a.m., NA-E entered room to get resident ready for breakfast. NA-E informed R15 that she was going to remove the gown and R15 said "Ouch" while the gown was removed. NA-E asked what was wrong and R15 stated my leg hurts and rated the pain at "7" on scale of 0-10. NA-E asked if R15 had any pain medication and R15 said they had given her some at 5 a.m., NA-E then said that it must have not kicked in yet. NA-E continued to complete	2 830			

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2 830	Continued From page 8 cares for R15. R15 said " ouch, that hurts " , several times with movement. During an interview after R15 ' s cares, NA-E said that R15 always felt " crampy " [having feeling of pain] and R15 preferred to stay in bed a lot and frequently refused to be repositioned. A quarterly Minimum Data Set (MDS) (a resident assessment and care screening tool) was completed 12/8/11. The MDS indicated that R15 was able to clearly express ideas and wants. A brief interview for mental status (BIMS) (cognitive assessment) was completed and R15 scored 11 out of 15 which indicated moderate impairment in mental status. The MDS also indicated R15 had almost constant pain that made it hard to sleep at night and limited day-to-day activities. R15 had rated the pain as a 10 however the intensity section of the pain section had not been completed on this MDS. R15 ' s care plan date initiated 1/11/11 and revised on 12/9/11, indicated that R15 had identified pain management needs and monitoring needs related to generalized deconditioning (decline), bilateral knee contractures (which R15 was admitted with) due to mild Parkinson ' s disease, seizure disorder and left ulnar neuropathy with a goal to maintain adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain, distress or verbalizing satisfaction with level of comfort. There had been no new pain interventions added to the care plan since 1/11/11. Review of R15 ' s current physician orders dated 1/24/12 revealed that R15 had the following pain medications: neurontin 400 milligram (mg) (used for chronic pain and neuralgia) three times a day, oxycodone hydrochloride 10 mg every day, oxycodone hydrochloride 5 mg every day, oxycodone hydrochloride 5 mg every three hours as prn (needed), Tylenol extra strength 1000 mg	2 830			

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2 830	Continued From page 9 three times a day, baclofen 7.5 mg (used for treatment of spasticity) three times a day. The quarterly clinical health status form dated 9/23/11 completed by registered nurse (RN) clinical manager-B indicated R15 had constant, burning, aching, throbbing pain in legs and back with a pain rating of " 7 " on a scale of 1-10. R15 ' s acceptable level of pain was 6. The documentation indicated that the pain impacted quality of life, sleep, functioning and mood. The clinical health status form identified " current pain treatment plan: tylenol, oxycodone, repositioning " " Effective " . The quarterly clinical health status form dated 12/9/11 at 8:00 a.m. completed by registered nurse (RN) -B indicated R15 had constant, sharp pain in left hip and thigh with a pain rating of " 6 " on a scale of 1-10. R15 ' s acceptable level of pain was " 4 " on scale of 0-10. The documentation indicated that the pain impacted quality of life by limiting activities. The clinical health status form identified " current pain treatment plan: oxycodone, baclofen, sinemet " " Effective " . During review of the medication administration record (MAR) along with the pain monitoring tool, the following was noted concerning R15 ' s use of as needed pain medication: July 2011, R15 had received 7 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 8 to 10. August 2011, R15 had received 13 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 6 to 10. September 2011, R15 had received 3 as needed (PRN) doses of oxycodone 5 mg for pain rating ranging from 8 to 10. October 2011, R15 had received 13 PRN doses of oxycodone 5 mg for pain rating ranging from 7 to 10. November 2011 it revealed 41 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. December 2011	2 830		

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2 830	Continued From page 10 revealed 38 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. January 2012 revealed 25 PRN doses of oxycodone 5 mg was given for pain ratings ranging from 6-10. For the month of February 2012 it revealed 17 PRN doses of oxycodone 5 mg had been given for pain rating ranging from 7-10. Upon review of the effectiveness of the PRN pain medication from July 2011 to March 1, 2012, it was noted that numerous doses of pain medication had not been evaluated for effectiveness. A review of progress notes indicated the following concerns with pain as follows: On 10/20/11 at 9:17 p.m., written by licensed practical nurse (LPN)-A indicated that resident R15 was alert, orientated, and able to communicate her needs to staff ...Resident complained of pain of 8 out of 10. R15 received a scheduled tylenol and oxycodone. However, there had been no follow up documentation on the effectiveness of these pain medications. On 11/21/11 at 14:51 (2:51 p.m.), written by registered nurse (RN)-D said that R15 received prn oxycodone 5 mg at 10:00 a.m. for pain in legs which had been rated 10 out of 10 (worst pain possible.) Follow up rating was 7 out of 10. On 11/24/11 at 11:39 p.m. written by RN-E said that the resident continued to complain about pain affecting both legs, pain rating at a 9 to 10. This was two hours after the resident received as needed oxycodone. No other interventions or follow up was noted following the complaint of severe pain not being relieved. On 12/1/11 at 10:26 p.m. written by LPN-A said that R15 offered complaints of pan in hip and legs this evening at 9:30 p.m. and received an as needed oxycodone 5 mg. No follow up documentation on the effectiveness of pain medication was documented. On 2/23/12 at 2:21 p.m. written by LPN-B	2 830		

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2 830	Continued From page 11 revealed resident was alert and oriented, resident refused shower this shift due to pain and resident rated pain at an 8. LPN-B administered prn oxycodone and it had provided little relief. During an interview on 3/1/12 at 7:11 a.m., RN-C, who worked the night shift, indicated that the previous shift had given R15 pain medication around 9 p.m. the evening before and then RN-C usually gives another as needed pain dose around 4:00 a.m. RN-C stated she had not noticed any changes in pain, just that the pain increased with movement. Staff would offer reassurance, deep breathing and repositioning. R15 usually rated her pain as 8-10. RN-C stated she would go back in R15 's room to check on the resident about an hour after prn pain medication was given and R15 was usually sleeping. RN-C said that R15 was repositioned every 2 hours during the night shift and usually complained of pain during repositioning. During an interview on 3/1/12 at 7:55 a.m., registered nurse clinical manger (RNCM)-A who had worked the day shift, verified that R15 had chronic pain and received pain medication. RNCM-A verified that R15 had an order for oxycodone 10 mg at 6 a.m. and 5 mg at 5 p.m. and an order for oxycodone 5 mg every 3 hours as needed for pain, along with routine tylenol extra strength. RNCM-A confirmed that R15 had been on this combination of medications for quite some time. RNCM-A stated that the licensed nurses would let RNCM-A know of any changes in R15 's pain and prn medication frequency and then she would let the nurse practitioner know. The nurse practitioner would than look for frequently used prn medications and if the pain was controlled with the scheduled medications than may need to adjust times and doses. When asked about the increase in PRN oxycodone medication use from October 2011 to current	2 830			

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2 830	Continued From page 12 date (March 1, 2012), the RNCM-A indicated that she was unaware of the frequency of use. RNCM-A felt that R15 ' s pain was managed as well as it can be managed and that R15 came to the facility with the contractures and chronic pain. On 3/1/12 at 8:42 a.m., a family member (F1) was interviewed and confirmed R15 had experienced a lot of pain and there were times where the pain did go away. F1 indicated that mornings were rough for R15. F1 indicated that pain management had been discussed during quarterly care conferences and it was said that when R15 begins to feel pain she was to put on the call light. F1 indicated that R15 had rated the pain from 8-10. F1 indicated that they were not aware of any discussion on other options available for pain management for the past several months. F1 discussed bringing up acupuncture as an option for pain relief to the facility and felt it may be a good idea that R15 be reevaluated for pain control. On 3/1/12 at 1:23 p.m., R15 ' s primary medical doctor (MD) was contacted and verified that R15 had a diagnosis of thoracic neuropathy and felt that pain management had been thoroughly addressed. The MD said that she and the nurse practitioner discussed the resident ' s current health conditions, medications R15 currently receives and possible side effects. They had also discussed the possible use of an anti-Parkinson ' s medication to help with mobility. When asked about the pain management for R15, MD indicated that she would expect the facility staff to update her if there was a change in R15 ' s pain so further evaluation could be done. On 3/1/12 at 1:56 p.m., the Director of Nursing (DON) was interviewed and indicated that R15 gets very nervous and anticipatory of pain any	2 830			

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2 830	Continued From page 13 time staff want to move her. The DON indicated that staff administers pain medication before moving R15. When questioned about R15 's ongoing use of prn pain medication and lack of monitoring of medication effectiveness since October 2011, the DON said that she would expect the staff to inform the NP to assess the resident 's pain management regimen. The DON indicated the staff needed to complete a comprehensive pain assessment on R15 as soon as possible and have the NP reviews it to evaluate the effectiveness of the pain regimen. During a telephone interview on 3/2/12 at 8 " 18 a.m., the NP responsible for R15 's care, indicated that R15 would never fully get rid of pain and spasms, that she was aware the spasms were worse in the morning and when applying braces on both legs, and indicated the spasms/pain got better throughout the day. The NP indicated R15 received oxycodone before cares were provided and before putting on the leg braces. NP indicated R15 had been seen by her on 1/30/12 and R15 's pain management was evaluated and seemed to be the best at this time. NP indicated that there had been no nursing concerns expressed to her in regards to R15 's pain management. NP verified she had not been informed by nursing staff of the lack of pain medication effectiveness from October 2011 through February 2012. NP indicated that she evaluated the underlying condition/s for R15 's medication regimen especially how they affect the heart and kidney function. NP verified that physical therapy interventions had been attempted over the past year for R15. R49 had bruising that was not identified or monitored.	2 830			

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2 830	Continued From page 14 R49 was admitted to the facility on 6/18/10 with diagnoses including cerebral vascular disease with hemiplegia, recurrent thromboembolism, and debility and received anticoagulant medications. On 2/27/12 at 7:19 p.m., R49 had a bruise on outer aspect of left arm above the elbow. R49 was unaware of the bruise and how it had happened. Review of the resident's record did not show any documentation of the bruised area on the left arm. R49's care plan with date initiated 10/25/10 was reviewed and it indicated R49 was at risk for complications related to anticoagulant medication secondary to diagnosis of recurrent thromboembolism and history of CVA (cardio-vascular attack or stroke). Interventions included observe for signs and symptoms of bleeding: tarry stools, blood in urine, bruising, petechiae. On 3/1/12 at 8:36 a.m., registered nurse (RN) clinical manager-B indicated she was unaware of a bruise and verified that there was no documentation regarding a bruise on his arm and that she would go and assess the area at this time. On 3/1/12 at 9:13 a.m., RN-B indicated that when staff identified bruises it was to be reported to the nurse manager and the executive director. Staff perform an investigation, measure the area, document and investigate further to make sure resident was safe. Staff performs a skin inspection weekly and nursing assistants are to let the nurses know if bruises are noted during	2 830		

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2 830	Continued From page 15 cares. On 3/1/12 at 1:49 p.m., director of nursing (DON) confirmed the clinical manager would take measurements, talk with resident to ensure no abuse and investigate what happened when a bruise had been identified. R6 lacked a skin assessment and monitoring of a bruise. R6 was observed at 4:56 p.m., on 2/27/2012, to have bruising on the back of both hands, forearms and finger. Incident reports were reviewed from 12-11-11 to 2-11-12 and no reports identified bruises on the resident. Primary Care Internal Med Nursing Home Limited Exam completed 7/12/11 by the certified nurse practitioner (CNP) indicated R6 had been experiencing an increase in bruising of forearms and hands. Review of quarterly Minimum Data Set (MDS) dated 2/8/12 revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene and required supervision with locomotion by wheelchair. MDS did not identify concern with bruising. Care plan dated 1/10/12 did not identify risk for bruising with interventions to decrease risk for bruising. During an interview at 11:22 a.m., on 2/29/12, clinical manager (CM)-B stated R6 does always pay attention to where going and gets bruises from hitting hands and arms on things when moving around. CM-B stated there are no incident reports or nursing notes related to	2 830			

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2 830	Continued From page 16 bruising on back of R6 's hands and forearms. CM-B indicated the bruising should have been assessed when found and documented. During an interview at 2:40 p.m., on 2/29/12, CM-B stated that she and the CNP believed the bruising was chronic and related to kidney disease. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all resident's health issues are properly monitored. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by:	2 895		

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2 895	Continued From page 17 Based on observation, interview, and record review, the facility failed to ensure range of motion was provided according to the assessed needs for 2 of 3 residents (R89 and R6) in the sample reviewed for range of motion. Findings include: R89 did not receive range of motion (ROM) services according to their assessed needs. R89 was admitted to the facility on 12/18/08, with diagnoses that included, but were not limited to: Alzheimer disease, dementia with behavioral disturbances and adult failure to thrive. Review of the physician orders revealed that the resident had the following range of motion exercise ordered since 7/2/09: Hamstring stretch with feet up on chair/ lowered bed for 5-10 minutes two times a day. Review of the restorative documentation record for R89 for the month of February 2012 revealed that of 58 opportunities the hamstring stretches were completed "0" zero times. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident 's refusal. Review of the restorative documentation record for R89 for the month of January 2012 revealed that of 62 opportunities, the hamstring stretches were completed "22" twenty-two opportunities. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident 's refusal. Review of the restorative documentation record	2 895			

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2 895	Continued From page 18 for R89 for the month of December 2011 revealed that of 62 opportunities, the hamstring stretches were completed "24" twenty-four opportunities. The restorative record for all of the other opportunities were either left blank or had a refused identified. The restorative record had not identified the reason for the resident 's refusal. During interview with the Registered Nurse Clinical Manager-A on 2/29/12, at 9:53 a.m. She confirmed that the resident should be having hamstring stretch with feet up on chair/lowered bed for 5-10 minutes offered twice a day. She confirmed that the rehab program was not consistently implemented and the nursing assistant assigned to the residents care should have written an explanation of why the range of motion exercise or reasons for refusal on the restorative record if the range of motion exercise was not completed. Resident (R6) lacked development of restorative nursing/range of motion per physical therapy recommendation. R6 was admitted on 6/15/2010, with diagnoses that included but are not limited to history of stroke, history of hip fracture and joint replacement and osteoarthritis. At 11:47 a.m., on 2/29/12, R6 was observed during a transfer from a sitting position to a standing position. R6 was observed to perform a pivot transfer with assist of staff. R6 knees were bent and together. Hinged brace was in place on left knee. Interview with R6 at 4:43 p.m., on 2/27/12 and R6 stated she needed staff assistance to get in and out of bed.	2 895			

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2 895	Continued From page 19 Review of quarterly Minimum Data Set (MDS) dated 2/8/12, revealed moderate cognitive impairment, extensive assist with bed mobility, transfers, walking, dressing, toilet use, personal hygiene. MDS did not indicate use of restorative nursing programs. Care plan print date of 1/10/12, lacked care plan interventions for range of motion/restorative nursing. Rehab Recommendations dated 9/8/11 included hamstring stretches twice a day after each meal. Rehab Recommendations dated 1/27/12, included " after each meal, lower the bed, put feet up to stretch hamstrings/knees. Remind [R6] to relax and push knees straight 10-15 [times]. " Physical therapy program coordinator was interviewed at 3:21 p.m., on 2/29/12 and indicated therapy sets up restorative programs. Physical therapy program coordinator stated R6 was discharged from therapy on 2/24/11 and was to continue with restorative exercises. She indicated procedure was for therapy to hand over the restorative program to the clinical managers. Restorative Guideline procedure (undated) was reviewed. Restorative nurse coordinator with input from therapy makes resident selections. Restorative coordinator initiates the restorative nursing worksheet and restorative nursing staff document on the worksheet. Restorative nursing worksheets for December 2011, January 2012 and February 2012 did not identify therapy recommendations for hamstring stretches. During an interview on 3/1/12, 9:15 a.m., with clinical manager (CM)-B, CM-B indicated she was	2 895		

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2 895	Continued From page 20 in charge of the restorative program on second floor and stated she has not been monitoring for compliance. CM-B verified documentation of restorative program for R6 was not completed consistently. CM-B verified the hamstring program was not included in the restorative program as recommended by physical therapy. CM-B stated she received education on 3/1/12 from a clinical consultant on restorative programs. CM-B stated she plans to start monitoring the restorative program for compliance and effectiveness. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 895			
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by:	21325			

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21325	Continued From page 21 Based on observation, interview, and record review, the facility failed to reassess oral health status and provide dental services for 1 of 1 resident (R132) in the sample who had complaints of teeth pain. Findings include: R132 voiced complaints of multiple tooth pain that had not been assessed and dental services had not been provided timely. R132 was observed on 2/28/12 at 9:17 a.m. during which it was noted that the resident had multiple broken and carious teeth. It was noted that a thick layer of white debris coated the resident's teeth. During interview with the resident at that time he stated that he had pain in his teeth. Review of the nursing progress notes for the month of February 2012 revealed that there were no comments or assessment of oral status or tooth pain for R132. Registered Nurse (RN) Clinical Manager B was interviewed on 3/1/12 at 8:20 a.m. during which she confirmed that the resident had complained of tooth pain the previous week she confirmed that the residents medical record did not contain comments or assessment of oral status or tooth pain for R132. RN clinical manager B did state that she notified the nurse practitioner of the issue but the resident's record did not contain any evidence that the nurse practitioner had addressed the concern. RN clinical manager B provided documentation of a nurse practitioner visit entered on 3/1/12, at 1:12 p.m. that identified the following: "2/24/12, [RN clinical manager B] informs me that pt had c/o tooth ache to tablemate. Pt has missing teeth,	21325			

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21325	Continued From page 22 no drainage, no redness, no swelling, no fever. Pt is eating and drinking without difficulty. Pain apparently is intermittent on the right side, but is unable to pinpoint or c/o any pain when asked. advised nonemergent dental appt. notify me of any increase in [symptoms] esp [especially] swelling..." Review of the care plan (unable to find date in electronic medical record) the following interventions were identified related to dental: Assistance with oral care as needed. Inspect oral cavity for bleeding of gums or other issues. Medication and or treatment as ordered. Refer for Dental services as needed. Further interview with Registered Nurse (RN) Clinical Manager B was interviewed on 3/1/12, at 8:20 a.m. she stated that she put the resident on the list for a dental exam for the next time the contracted dental services were coming to the facility but did not know when that would be. The clinical manager then called the director of nursing and asked her when the dental company who provides the facility with routine dental services was coming to the building and she stated that she did not know and that they would get back to me. The director of nurses came back on 3/1/12 at approximately 8:45 a.m. and stated that the contracted dental services were not scheduled to come to the facility for routine dental care until 3/13/12 (18 days after the resident complained of tooth pain.) SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review the policies and procedures regarding the acquisition of dental services for residents. Audits of the admission forms could be completed to ensure that dental services if indicated or needed have	21325			

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21325	Continued From page 23 been ordered or done. Training for all personnel to ensure compliance could be done. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21325			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to maintain an infection control program that would analyze infection trends and patterns of infections in the facility in order to prevent, recognize, and control the spread of infection. This had the potential to affect all 102 of 102 residents in the facility. Findings include: The facility's " Line Listing of Resident Infection " surveillance forms were reviewed for October, November and December 2011. The surveillance sheets was to include the following information: resident name, room number and unit, admission date, type of infection, date and onset of symptoms, cultures (including date done, site and result), treatment to include type of medication and when the infection was resolved, and whether or not an infection is nosocomial (infections that develop as a result of a stay in hospital.) The infection control surveillance forms were consistently not completed in an organized,	21375			

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21375	Continued From page 24 legible and systematic manner and revealed the following: October 2011: 24 out of 25 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. November 2011: 10 out of 12 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. December 2011: 22 out of 22 entries made on the surveillance form were incomplete and did not include the necessary components to track and trend infections. On 3/1/2012, at 1:21 p.m. the Infection Control Nurse (ICN) was interviewed and confirmed the "Line Listing of Resident Infections" forms were not complete with the information to aide in analysis and tracking of resident infections. The ICN confirmed there was a lack of consistency related to data collection and analysis of the information. On 3/1/2012, at 3:00 p.m. the director of nursing (DON) was interviewed regarding the infection control program. The DON stated the program "was not where it needs to be" because the ICN was also responsible for hiring new employees and that was more of a priority. The facility's policy/procedure titled "Introduction Infection Control in Long-Term, Care" dated 2001 with a revision date of October 2011. The policy indicated that the infection control program should have components to include employee health, environmental infection control, and	21375			

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21375	Continued From page 25 surveillance and reporting, managing the infection control aspects of various clinical conditions, and immunization and vaccination. Suggested Method of Correction: The administrator or designee could review policy and procedures regarding infection control. Facility could educate staff on policy and procedures and develop a monitoring system to ensure compliance. Time Period for Correction: Twenty one (21) days.	21375			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the	21530			

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21530	Continued From page 26 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 have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility consultant pharmacist failed to identify irregularities and report them to the physician and director of nursing concerning adequate monitoring for effectiveness of narcotic usage for 1 of 1 resident (R15), adequate indications for anti-depressant medication for insomnia for 1 of 1 resident (R117) and lacked laboratory tests for anti-cholesterol medications for 1 of 10 residents (R6). Findings include: R15 received received oxycodone (a narcotic pain medication), but lacked monitoring of the effectiveness of the medication. R15, admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a physician's order for oxycodone hydrochloride 5	21530			

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21530	Continued From page 27 mg every three hours as prn (needed) for pain. Review of the medication administration record (MAR) revealed that resident had received oxycodone 5 mg every three hours prn for pain. The documentation was not completed for the effectiveness of the pa in medication. Review of November MAR revealed that R15 had received oxycodone prn 41 times and had follow-up documentation 26 times, but included pain rating only 5 times in follow up documentation. Review of December MAR revealed that R15 had received oxycodone prn 38 times and had follow-up documentation 20 times, but included pain rating only 3 times. Review of January MAR revealed that R15 had received oxycodone prn 25 times with follow-up documentation done 16 times, but included pain rating 1 time. Did not receive prn sheet for the month of February that was requested on 3/1/12 and 3/2/12. Review of MAR revealed that R15 had an increased usage of oxycodone since November. On 3/1/12 at 1:02 p.m., interview with pharmacy consultant revealed that the increase in oxycodone was not addressed. Pharmacy consultant indicated that he would not be concerned about the increase in prn pain medication but would be concerned about constipation and fall side effects. He indicated that he did not feel the lack of identification of the increased prn pain medication was a big deal. R117 was on trazodone medication used as a sleep aid for insomnia. No sleep assessment to identify patterns or routine of sleep was completed prior to initiation of the sleep aid medication. According to physician orders dated 10/19/2011, R117 was receiving Trazodone 100 mg. at bedtime for insomnia.	21530			

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21530	Continued From page 28 Pharmacy reviews dated 4/28/2011 through 2/2012 were reviewed. The pharmacy reviews addressed the use of trazodone but did not address the need for a sleep assessment. On 2/29/2012 at 11:30 a.m., Clinical Manager (CM)-A was interviewed. She indicated the resident was admitted on 3/31/2011 and the trazodone medication initially was started on 4/11/2011, increased several times, and then decreased to 100 mg. for insomnia. The CM verified a sleep assessment should have been done initially but it had not been done. R6 lacked consultant pharmacist identification of irregularities related to laboratory results and diabetes management. R6 was admitted to the facility on 6/15/2010 and had diagnosis that included but not limited to: hypoglycemia, chronic kidney disease, diabetes. R6 had physician orders dated 6/15/10 for Simvastatin 10 mg at bedtime for high lipid levels. Insulin NPH 20 units ordered 5/9/11 for diabetes management but lacked laboratory results monitoring cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). Physician order dated 11/20/11 directed staff to test the resident's blood glucose levels twice daily and to notify the CNP if blood glucose levels were less than 100 or greater than 150. Review of medication administration record (MAR) for R6 revealed in February 2012 R6 experienced blood glucose levels in excess of 150 for periods of	21530			

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21530	Continued From page 29 three to six consecutive days three times during the month. Reviewed laboratory results identified in clinical record dated 7/18/11 and laboratory results lacked monitoring of cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). On 3/1/12, at 12:45 p.m., clinical nurse manager -B was interviewed and indicated medication procedure was to obtain laboratory results twice a year. She indicated that she was unable to find cholesterol results and verified CNP was not notified of elevated glucose levels. The consultant pharmacist (CP) was interviewed by telephone at 3:10 p.m., on 3/2/12. CP stated a baseline liver functioning test is completed one time and recommends every six months after. CP stated cholesterol panel guideline is for completion of a cholesterol panel yearly and stated again he recommends every six months. CP stated A1C was not needed for blood glucose monitoring. He stated he reviews blood sugars and makes recommendations as needed. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		

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21535	Continued From page 30	21535			
21535	MN Rule 4658.1315 Subp. 1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate monitoring for effectiveness of narcotic usage for 1 of 1 resident (R15), adequate indications for anti-depressant medication for insomnia for 1 of 1 resident (R117) and lacked laboratory tests for anti-cholesterol medications for 1 of 10 residents (R6) in the sample. Findings include: R15 received oxycodone (a narcotic pain	21535			

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21535	Continued From page 31 medication), but lacked monitoring of the effectiveness of the medication. R15, admitted to the facility 4/5/10, with diagnoses that included, but were not limited to: lower extremity spasticity in the setting of known thoracic myelopathy, peripheral neuropathy, mild Parkinson's disease, left ulnar neuropathy, and pain secondary to neuropathy and spasms. R15 had a physician's order for oxycodone hydrochloride 5 mg every three hours prn (as needed) for pain. Review of the medication administration record (MAR) revealed that resident had received oxycodone 5 mg every three hours prn for pain. The documentation was not completed for the effectiveness of the pain medication. Review of November 2011 MAR revealed that R15 had received oxycodone prn 41 times and had follow-up documentation only 26 times and included pain rating only 5 times in follow up documentation. Review of December 2011 MAR revealed that R15 had received oxycodone prn 38 times and had follow-up documentation 20 times, but included pain rating only 3 times. Review of January 2012 MAR revealed that R15 had received oxycodone prn 25 times with follow-up documentation done 16 times, but included pain rating 1 time. Did not receive prn sheet for the month of February that was requested on 3/1/12 and 3/2/12. Review of MAR revealed that R15 had an increased usage of oxycodone since November 2011. On 3/1/12 at 7:55 a.m., RN clinical manager-B verified that R15 had chronic pain and received pain medication. RN clinical manager verified that R15 had an order for oxycodone 5 mg every 3 hours as needed for pain. RN clinical manager revealed that the licensed nurses would let the RN clinical manager know of any changes in pain and prn frequency and then would let the nurse	21535		

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21535	Continued From page 32 practitioner know to review. The nurse practitioner would than look for frequently used prn medications and if the pain was controlled with the scheduled medications than may need to adjust times and doses. RN clinical manager indicated that she was unaware of any changes in the amount of prn usage for the past few months for R15. RN clinical manager felt that R15's pain was managed as well as it can be managed. On 3/1/12 at 1:56 p.m., Director of Nursing (DON) was interviewed and indicated that R15 gets very nervous and anticipatory of pain any time staff want to move her. DON would expect the staff to take the information to the NP if using excessive prn medications and would bump up the medication to something more effective. DON verified that the staff need to get another pain assessment done and into the NP as soon as possible. R117 received trazodone (an antidepressant used as a sleeping aid) for insomnia without adequate indications. A review of documents revealed the physician ordered trazodone 50 mg. orally at bed time for insomnia on 4/11/2011. The physician ordered increases to the medication up to 200 mg at bedtime and then on 10/19/2011, the physician ordered a decrease to 100 mg orally at bed time. R117 was currently receiving the 100 mg dose at bedtime. A physician note dated 4/11/2011 was reviewed. It noted "patient has a main complaint to me today of insomnia. " "Would like to start a low dose of trazodone" On 2/29/2012 at 11:30 a.m., Clinical Manager	21535			

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21535	Continued From page 33 (CM)-A was interviewed. She indicated the resident was admitted on 3/31/2011 and the trazodone medication initially was started on 4/11/2011, increased several times and then decreased to 100 mg for insomnia. The CM verified a sleep assessment should have been done initially but it had not been done. The facility policy and procedure for Sleep Problems, undated, indicated the team needed to assess the resident's routine and customary habits to determine if the sleep disturbance was a problem. R6 lacked blood laboratory results for use of anti-cholesterol medications and diabetes management and Certified Nurse Practitioner (CNP) notification of blood glucose levels out of identified range. R6 was admitted to the facility on 6/15/2010 and had diagnosis that included but not limited to: hypoglycemia, chronic kidney disease, diabetes. R6 had physician orders dated 6/15/10 for Simvastatin 10 mg at bedtime for high lipid levels. Insulin NPH 20 units ordered 5/9/11 for diabetes management. Reviewed laboratory results identified in clinical record dated 7/18/11 and laboratory results lacked monitoring of cholesterol levels and A1C levels. (Laboratory results used to monitor diabetes management). On 3/1/12, at 12:45 p.m. clinical manager (CM)-B was interviewed and indicated medication procedure was to obtain laboratory results twice a year. She indicated that she was unable to find	21535			

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FORM APPROVED

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21535	Continued From page 34 cholesterol results. Physician order dated 11/20/11 directed staff to test the resident ' s blood glucose levels twice daily and to notify the CNP if blood glucose levels were less than 100 or greater than 150. Review of medication administration record (MAR) for R6 revealed in February 2012 R6 experienced blood glucose levels in excess of 150 for periods of three to six consecutive days three times during the month and these had not been reported to the CNP. On 3/1/12, at 12:45 p.m. CM-B verified CNP was not notified of elevated glucose levels. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535			
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.	21942			

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21942	Continued From page 35 This MN Requirement is not met as evidenced by: Based on interview the facility failed to make an attempt to form a family council. Findings include: Clinical Nurse Manager at 4:30 p.m., on 2/29/12 stated facility did not have a current family council. Activity Director was interviewed at 8:34 a.m., on 3/1/12. She had started in 2010 and the facility did not have a family council prior to her starting her position. She stated there had been no attempts or discussions to start a family council to her knowledge. She stated would check with the administrator to see if administration had attempted to start a family council. At 2:40 p.m., on 3/1/12, no further information on annual attempt to start family council was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee will contact families and attempt to begin a family council. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21942			