1. MEDICARE/MEDICAID PROVIDER NO.

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITT PART I - TO BE COMPLETED BY THE STATE SURVEY AGE

3. NAME AND ADDRESS OF FACILITY

TAL NCY		LZZ9 cility ID: 00866
	4. TYPE OF ACTION:	7 (L8)
	1. Initial	2. Recertification
5303	3. Termination 5. Validation	4. CHOW 6. Complaint
22 CLIA	7. On-Site Visit  8. Full Survey After Com	9. Other plaint
	FISCAL YEAR ENDING D	DATE: (L35)
Waivers Of The	Following Requirements:	
cal Personnel	6. Scope of Service	
r RN RN (Rural SNF)	7. Medical Directo	
fety Code	9. Beds/Room	

(L3) GOLDEN LIVINGCENTER - TWIN RIVERS (L4) 305 FREMONT STREET 2 STATE VENDOR OR MEDICAID NO (L2)400099400 (L5) ANOKA, MN (L6) 55 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 02 7. PROVIDER/SUPPLIER CATEGORY (1.9)01 Hospital 05 HHA 09 ESRD 13 PTIP 02 SNF/NF/Dual 06 PRTF 6 DATE OF SURVEY 06/01/2016 (L34) 10 NF 14 CORE 8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 11 ICF/IID (L10) 07 X-Ray 15 ASC 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 2 AOA 3 Other 11 LTC PERIOD OF CERTIFICATION 10 THE FACILITY IS CERTIFIED AS: From (a): X A. In Compliance With And/Or Approved 2. Technic (b): Program Requirements To Compliance Based On: \_\_\_\_ 3. 24 Hou 1. Acceptable POC 4. 7-Day F 12. Total Facility Beds **56** (L18) \_\_\_ 5. Life Sa 56 (L17) 13. Total Certified Beds B. Not in Compliance with Program (L12) Requirements and/or Applied Waivers: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS (L15) 18 SNF 18/19 SNF IID 19 SNF ICF 1861 (e) (1) or 1861 (j) (1): 56 (1.37)(1.38)(1.39)(1.42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Mandatory DOPNA, effective 05/25/2016, is rescinded effective 05/25/2016. Facility's request for temporary waivers involving K025, K027, K033, K051 is approved. 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL 06/16/2016 William Abderhalden, DSFM Kate JohnsTon, Program Specialist (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) 2 Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: \_X 1. Facility is Eligible to Participate 3 Both of the Above Facility is not Eligible (L21)22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 10/01/1985 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24) (L41) (L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44)(L27) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00454 (L28)(L31) Posted 07/11/2016 Co. 32 DETERMINATION OF APPROVAL DATE 31 RO RECEIPT OF CMS-1539 04/15/2016 (L32) (L33) DETERMINATION APPROVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6146 CMS Certification Number (CCN): 245298 June 24, 2016

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, Minnesota 55303

Dear Ms. Lyon:

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 May 25, 2016 the above facility is certified for or recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

Your request for waivers of K025, K027, K033, and K051 has been approved based on the submitted documentation.

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

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your

Golden Livingcenter - Twin Rivers June 24, 2016 Page 2

Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6146 June 23, 2016

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, Minnesota 55303

RE: Project Number S5298027

Dear Ms. Lyon:

On May 18, 2016, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective May 23, 2016. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 25, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 18, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 25, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on February 25, 2016, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our May 18, 2016 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 16, 2016, the Minnesota Department of Public Safety 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 February 25, 2016 and a Federal Monitoring Survey completed March 8, 2016. We presumed, based on your plan of correction, that

Golden Livingcenter - Twin Rivers June 23, 2016 Page 2

your facility had corrected these deficiencies as of May 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2016, as of May 25, 2016.

As a result of the PCR findings, this Department is taking the following action:

• State Monitoring is discontinued effective May 25, 2016.

Additionally, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of May 18, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 25, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 25, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 25, 2016, is to be rescinded.

In our letter of May 18, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 25, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 25, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiencies cited under K025, K027, K033, K051 at the time of the February 25, 2016 standard survey, has not yet been verified. Your plans of correction for these deficiencies, including your request for a temporary waiver with a date of completion of August 1, 2016, have been approved. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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.

Golden Livingcenter - Twin Rivers June 23, 2016 Page 3

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

			POST	-CERTIFIC	AHON	REVISIT RE	PORT		
	R / SUPPLIER / (		MULTIPLE CONS	STRUCTION				D	ATE OF REVISIT
245298	ATION NUMBER	R Y1	A. Building B. Wing					<sub>Y2</sub> 6.	/1/2016 <sub>Y3</sub>
NAME OF	FACILITY	- 11				STREET ADDRESS, CIT	Y STATE ZIP CODE	12	13
	LIVINGCENT	ER - TWIN	RIVERS		I	305 FREMONT STREET			
						ANOKA, MN 55303			
program, corrected provision	to show those and the date s	deficiencie such correc	es previously repo etive action was a	orted on the CMS-25 accomplished. Each	567, Stateme deficiency s	nd/or Clinical Laborator ent of Deficiencies and should be fully identifie 567 (prefix codes show	Plan of Correction, dusing either the re	that have be gulation or L	SC
ITEN	И		DATE	ITEM		DATE	ITEM		DATE
Y4			Y5	Y4		Y5	Y4		Y5
ID Prefix	F0441		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#	483.65		Completed	Reg. #		Completed	Reg. #		Completed
LSC			05/23/2016	LSC			LSC		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#			Completed	Reg. #		Completed	Reg. #		Completed
LSC			- '			·			·
				LSC					
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #			Completed	Reg. #		Completed	Reg. #		Completed
LSC			_	LSC			LSC		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#			Completed	Reg. #		Completed	Reg. #		Completed
LSC			=	LSC			LSC		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #			Completed	Reg. #		Completed	Reg. #		Completed
LSC			_	LSC			LSC		
REVIEWEI	D BY	REVIEW	/ED BY	DATE	SIGNATURE	OF SURVEYOR	<u>I</u>	ln.	ATE
STATE AG		(INITIAL		06/23/2016			794		06/01/2016
REVIEWEI	В В У	REVIEW (INITIAL		DATE	TITLE			D	ATE
FOLLOWU 2/25/2016	OLLOWUP TO SURVEY COMPLETED ON //25/2016				RECTED DEFICIENCIES NCIES (CMS-2567) SEN <sup>-</sup>		_	YES NO	

#### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01		
245298 <sub>Y1</sub>	B. Wing	Y2	6/16/2016 <sub>Y:</sub>
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN LIVINGCENTER - TWIN	RIVERS	305 FREMONT STREET	
		ANOKA, MN 55303	
This report is completed by a guali	fied State surveyor for the Medicare, Medicaid	and/or Clinical Laboratory Improvement Amendments	

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).

ITEI Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg.#	NFPA 1	)1	Completed	Reg. #	NFPA 101		Completed
LSC	K0027	05/25/2016	LSC	K0033		05/25/2016	LSC	K0048		04/05/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 1	)1	Completed	Reg. #	NFPA 101		Completed
LSC	K0050	04/05/2016	LSC	K0051		05/25/2016	LSC	K0052		04/05/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 1	)1	Completed	Reg. #	NFPA 101		Completed
LSC	K0054	04/05/2016	LSC	K0056		05/06/2016	LSC	K0064		04/05/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 1	)1	Completed	Reg. #	NFPA 101		Completed
LSC	K0069	04/05/2016	LSC	K0074		04/05/2016	LSC	K0076		04/05/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	)1	Completed	Reg. #			Completed
LSC	K0144	04/05/2016	LSC	K0147		04/05/2016	LSC			
	REVIEWED BY STATE AGENCY (INITIALS) BF/KJ		DATE 06/23/	2016	SIGNATURE OF SU	JRVEYOR 207	'94		DATE 06/1	6/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
<b>FOLLOW</b> ( 3/8/2016	JP TO SURVEY C	OMPLETED ON	_		ANY UNCORRECTE ED DEFICIENCIES (				YE	s 🗌 no



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6146 June 23, 2016

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, Minnesota 55303

Re: Enclosed Reinspection Results - Project Number S5298027

Dear Ms. Lyon:

On June 16, 2016 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 February 25, 2016, with orders received by you on March 16, 2016. 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,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

				STATE FO	RM: RE	VISIT REPORT					
IDENTIFIC	R / SUPPLIER / C		MULTIPLE CONS	TRUCTION					DATE OF R	EVISIT	
00866		Y1	B. Wing			1		Y2	6/1/2016	Y3	
	FACILITY		D.) (500			STREET ADDRESS, CIT		DDE			
GOLDEN	I LIVINGCENTE	R - IWIN	RIVERS			305 FREMONT STREET ANOKA, MN 55303					
corrective	e action was acc tion prefix code	complished	d. Each deficien	cy should be fully ide	entified usi	reported that have bee ng either the regulation es shown to the left of e	or LSC provision	n number and	the		
ITE	M		DATE	ITEM		DATE	ITEM			DATE	
Y4			Y5	Y4		Y5	Y4			Y5	
ID Prefix	21375		Correction	ID Prefix		Correction	ID Prefix		C	orrection	
Reg.#	MN Rule 4658.0 Subp. 1	800	Completed	Reg. #		Completed	Reg. #		C	ompleted	
LSC			05/23/2016	LSC			LSC				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection	
Reg. #			Completed	Reg. #		Completed	Reg. #		C	ompleted	
LSC			_	LSC			LSC				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection	
Reg.#			Completed	Reg. #		Completed	Reg. #		C	ompleted	
LSC			_	LSC			LSC _				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix —		C	orrection	
Reg. #			Completed	Reg. #		Completed	Reg. #		C	ompleted	
LSC				LSC			LSC				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix —		C	orrection	
Reg. #			Completed	Reg. #		Completed	Reg. #		C	ompleted	
LSC			_	LSC			LSC				
REVIEWE STATE AG		REVIEW (INITIAL		DATE 06/23/2016	1	RE OF SURVEYOR	794		DATE 06/01/2016		
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE	TITLE				DATE		
<b>FOLLOW</b> (2/25/2010	FOLLOWUP TO SURVEY COMPLETED ON 2:/25/2016					RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES	□ NO	

Page 1 of 1

EVENT ID:

LZZ913

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: LZZ9

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	F	acility ID: 00866
MEDICARE/MEDICAID PROVIDER N (L1) 245298  2.STATE VENDOR OR MEDICAID NO. (L2) 400099400	0.	3. NAME AND ADD (L3) GOLDEN LI (L4) 305 FREMO (L5) ANOKA, MN	VINGCENTER - NT STREET			(L6) <b>55303</b>	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY	09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other
6. DATE OF SURVEY <b>05/03</b> , 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 56 (L37) (L38)	56 (L18) 56 (L17) 19 SNF	X B. Not in Com	nce With quirements		235. * Code:	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	E Following Requirements:  6. Scope of Serviction 7. Medical Direct X 8. Patient Room S 9. Beds/Room (L12)  (L15)	or
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):	olving I	F354 and	F458 is recomm	mended,	
17. SURVEYOR SIGNATURE  Bruce Melchert, H.			05/03/2016 D BY HCFA RE	(L19)	Kate .	JohnsTon, Pr	ogram Specialis	Date: <u>t</u> 05/25/2016 (L20)
DETERMINATION OF ELIGIBILITY     1. Facility is Eligible to Part     2. Facility is not Eligible	icipate (L21)		IPLIANCE WITH C	IVIL	21.		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE  OF PARTICIPATION  10/01/1985  (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTAL 01-Merger, 0 02-Dissatisf	Closure action W/ Reimbursemen	INVOLUNT. 05-Fail to Me	ARY tet Health/Safety tet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			nvoluntary Termination ason for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMAR	RKS		
31. RO RECEIPT OF CMS-1539	(L32)	DETERMINATION ( 04/15/2016	OF APPROVAL DAT	(L33)	DETERM	IINATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 16, 2016

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, Minnesota 55303

RE: Project Number: S5298027

Dear Ms. Lyon:

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.

On March 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 25, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 21, 2016 CMS informed you that a Federal Monitoring Survey was completed on March 8, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 3, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 25, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 25, 2016. The deficiencies not corrected are as follows:

F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens F0458 -- S/S: B -- 483.70(d)(1)(ii) -- Bedrooms Measure At Least 80 Sq Ft/resident

As a result of our finding that the facility has not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

• State Monitoring effective May 23, 2016. (42 CFR 488.422)

However, as we notified you in our letter of March 10, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2016.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 4, 2016. Based on our PCR, we have determined that your facility has not corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2016.

Based on these findings, this Department is recommending to the CMS Region V Office that the following remedy be imposed:

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

In addition, we are recommending that the following remedy remain in effect:

Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 25,2016.
 (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 25, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 25, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Twin Rivers is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 18, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Correction of the Life Safety Code deficiencyies cited at the time of the February 25, 2016 standard survey, has not yet been verified. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of additional enforcement remedies.

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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338

Fax: (320)223-7348

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

submission.

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a 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 allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 August 25, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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.

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

#### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



CMS Certification Number (CCN): 245298

### March 21, 2016 By Certified Mail and Facsimile

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, MN 55303

Dear Ms. Lyon:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND

NOTICE OF IMPOSITION OF REMEDY

Cycle Start Date: February 25, 2016

#### STATE SURVEY RESULTS

On February 23, 2016, a Life Safety Code survey and on February 25, 2016, a health survey and complaint investigation were completed at Golden Livingcenter - Twin Rivers by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. The health survey and complaint investigation found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level F, cited as follows:

• F354 -- S/S: F -- 483.30(b) -- Waiver-Rn 8 Hrs 7 Days/wk, Full-Time Don.

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

### FEDERAL MONITORING SURVEY

In its notice dated March 10, 2016, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by April 5, 2016. Before a revisit was conducted, however, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on March 8, 2016. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level F, cited as follows:

- K25 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K27 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

- K48 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K51 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K56 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

#### PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

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

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

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Bruce Wexelberg, Safety Engineer Centers for Medicare & Medicaid Services Division of Survey and Certification 233 North Michigan Avenue, Suite 600 Chicago, Illinois 60601-5519 Email: Bruce.Wexelberg@cms.hhs.gov

#### INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are

disputing to, Jean Ay, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for <u>all</u> cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

#### LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is May 25, 2016.

#### SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

Mandatory Denial of Payment for New Admissions effective May 25, 2016

The authority for the imposition of remedies is contained in 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

### DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective May 25,

2016 if your facility does not achieve compliance within the required three months. This action is mandated by the Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify National Government Services that the denial of payment for all new Medicare admissions is effective on May 25, 2016. We will further notify the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective May 25, 2016.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

#### TERMINATION PROVISION

If your facility has not attained substantial compliance by August 25, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

#### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 25, 2016, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Golden Livingcenter - Twin Rivers will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2016. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

#### APPEAL RIGHTS

This formal notice imposed:

Mandatory Denial of Payment for New Admissions effective May 25, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at <a href="https://dab.efile.hhs.gov/user\_sessions/new">https://dab.efile.hhs.gov/user\_sessions/new</a> to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that <u>all</u> hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Nancy K. Rubenstein, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

#### **CONTACT INFORMATION**

If you have any questions regarding the Federal Monitoring LSC survey, please contact Bruce Wexelberg, Safety Engineer, at (312) 353-2859. Bruce Wexelberg's fax number is (443) 380-6756. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

/s/

Jean Ay
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

Minnesota Department of Health

cc: Minnesota Department of Human Services Office of

Ombudsman for Older Minnesotans

Stratis Health

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

PRINTED: 05/16/2018 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WNG				R
NAME OF P	;			EET ADDRESS, CITY, STATE, ZIP CODE	05	/03/2016	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS		305	FREMONT STREET DKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-RÉFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
SS=D	A post-certification (P on May 2 through May investigation(s) were of the PCR, Federal of this time.  Investigation of complete H5298057 were comparable substantiated.  The facility's plan of case your allegation of complete Department's accepta bottom of the first page be used as verification.  Upon receipt of an acceptation of the great acceptation of the first page be used as verification.  Upon receipt of an acceptation of the great acceptation of the great acceptation.  483.65 INFECTION Construction Control Programs, sanitary and complete sale, sanitary and complete sale program under which in the facility must estab program under which in the facility;	prrection (POC) will serve compliance upon the nce. Your signature at the e of the CMS-2567 form will of compliance.  Deptable POC an on-site will be conducted to validate ance with the regulations occordance with your  ONTROL, PREVENT  Lish and maintain an am designed to provide a fortable environment and welopment and transmission in.	{F 42		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 survey report. Our Plan of Correction is prepared and exect as a means to continuously improved the quality of care and to comply all applicable state and federal regulatory requirements.	the the ited ove	
ABOBATORYD	IDECTOR'S AR PROVIDERS	IPPI IPO REPRESENTATIVOS SIGNATUR					

Any deliciency 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 projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 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.

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

Event (D:LZZ912

Facility ID: 00868

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

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245298	B, WNG		R ·		
	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN R		\$	STREET ADDRESS, CITY, STATE, ZIP CODE 105 FREMONT STREET ANOKA, MN 55303	05/03/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BI  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)			
(F 441)	should be applied to a (3) Maintains a record actions related to infer (b) Preventing Spread (1) When the Infection determines that a resi prevent the spread of isolate the resident. (2) The facility must pr communicable diseas from direct contact will direct contact will trans (3) The facility must re hands after each direct hand washing is indica professional practice. (c) Linens Personnel must handle transport linens so as infection.	an individual resident; and of incidents and corrective ctions.  I of Infection of Control Program dent needs isolation to infection, the facility must rehibit employees with a e or infected skin lesions of their food, if smit the disease, equire staff to wash their ct resident contact for which ated by accepted	(F 441)	It is the policy of Golden Living Center Twin Rivers that the facility must est and maintain an Infection Control Prodesigned to provide a safe, sanitary comfortable environment and to prevent the development and transmiss disease and infection.  Plan of correction for identified incider Residents identified remain free infection due to nurse not wearing perprotective equipment (gloves). Feducation has been completed with involved in incidents noted during surv Nursing staff were educated in regards Infection Control Policy and the newear protective personal equipment there is possible contact with blood or fluids.  DNS or designee will complete waudits of medication administratio insulin, eye drops, and blood sugar cheasure ongoing compliance with Infe	ablish ogram		
	Based on observation, interview, and document review, the facility failed to ensure infection control protocol was followed when staff did not wear gloves during insulin administration for 3 of 5 residents (R123, R18, R40) observed during insulin administration.			Control policy.  QAPI Committee will provide directichange when necessary based on compliance noted.  Date of Completion: 5/24/16			
	Findings include: R123's diagnoses as in Minimum Data Set (MI type 2 diabetes mellitu	ndicated on the quarterly DS) dated 4/22/16, included s (metabolic disease		DNS or designee is responsible monitoring compliance.	for		

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

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							R
		245298	B. WNG	_		05/	03/2016
	ROVIDER OR SUPPLIER	RIVERS		36	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 441}	require insulin). Revi Summary Report on a received sliding scale day.	ood glucose levels and may ew of the physician Order 4/22/16 identified R123 Novolog insulin four times a	(F 4	41}			
	During observation of medication administration on 5/2/16, at 4:27 p.m., licensed practical nurse (LPN)-A primed R123's Novolog insulin pen and dialed up 8 units. LPN-A cleansed the abdomen with an alcohol wipe and injected R123's medication. LPN-A did not wash hands before or after the insulin administration, and did not wear gloves.						
	dated 4/18/16, include Review of the physicial	ndicated on quarterly MDS ed type 2 diabetes mellitus, an Order Summary Report d R40 received 3 units meals.					
	During observation of medication administration on 5/2/16, at 4:33 p.m. LPN-A primed R18's Novolog pen and dialed up 3 units. LPN-A wiped R18's abdomen with an alcohol wipe and injected he insulin. LPN-A did not wash hands before or following R18's injectable medication, and again, wore no gloves.						
	MDS dated 1/21/16, in mellitus. Review of the Report dated 4/5/16 id	ndicated on the quarterly ncluded type 2 diabetes e physician Order Summary dentified R40 received sliding scale, before meals.					
	on 5/2/16, at 4:50 p.m	medication administration LPN-A attached a needle lin pen, primed the pen, and					:

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

PRINTED: 05/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		245298	B. WING	_	i e	R /03/2016	
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F			3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 FREMONT STREET ANOKA, MN 55303	1 00.	010010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 441)	dialed a dose of 1 uni	it. LPN-A cleansed R40's ad and injected medication LPN-A did not wash hands	{F 4	141}			
	During interview on 5/02/2016 at 5:34 p.m., registered nurse (RN)-A who was also the nurse manager, stated "all staff members" should put on gloves prior to administering insulin. RN-A stated all licensed staff were provided education on proper insulin administration within the last month. She knowledged they had completed skills checklists for each licensed staff member within the facility, so they were aware to use gloves for insulin administration.  During interview on 5/2/16 at 6:03 p.m., the director of nursing (DON) stated all licensed staff members should be wearing gloves throughout the insulin administration process. The DON stated licensed nursing staff were tested out on this competency "within the last couple of months,"						
					·		
	dated 11/9/15, listed r including: "DONS cleat gloves," and "perform	expen Competency sheet numerous competencies, an gloves," "Removes is hand hygiene." A review sated LPN-A completed the cies on 3/24/2016.					
	dated 1/13/16, directed order for blood sugar gloves 3. Follow manual and care of the equipole	Blood Sugar Monitoring ad: "1. Check physician testing frequency 2. Put on ufacturer's directions for use ment used in your facility 4. n sharps container 5. Check					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/16/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245298		R			
NAME OF D					05	/03/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - TWIN F	RIVERS		305 FREMONT STREET			
	( <del>-</del>			ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		DBE	(X5) COMPLETION DATE	
{F 441}	Continued From page	4	{F 4	41}			
(F 458) SS=B	Apply Band-Aid as ne 483.70(d)(1)(ii) BEDR	OOMS MEASURE AT	{F 4!	F 458 Bedrooms measure at leas	t 80 sq		
55=5	Bedrooms must meas per resident in multiple	sure at least 80 square feet e resident bedrooms, and at in single resident rooms,		Golden LivingCenter-Twin Rivers like to request a waiver under F458 it to resident room size. The room included in this waiver are 4, 7, 17, 29, 35, and 36.	n regard s to be		
	by:	is not met as evidenced wavier for this federal		These rooms were constructed in I do not meet the current requirem square footage in two-bed rooms. no method available to increase the the rooms without causing hardship facility.	ents for There is size of		
,				Granting this waiver would not a affect the residents residing aforementioned rooms. The rehealth, treatments, comfort, safety as being will be maintained at the possible level. Currently there concerns or complaints from regarding their room size.	in the sidents' ad well- highest are no		
				The Director of Maintenance is respond to the monitoring of this was requirement.	onsible aivered		

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

			POST	-CERT	IFIC	ATION	IRE	VISIT RI	EPORT	•			
	R / SUPPLIER / CI CATION NUMBER		MULTIPLE CONS A. Building B. Wing	STRUCTION						Y2	DATE 0	OF REVISIT	
	FACILITY I LIVINGCENTE		RIVERS			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303							
program, corrected provision	to show those d and the date su	eficiencie: ch correct	s previously repo tive action was a	orted on the accomplishe	CMS-2 d. Eacl	567, Statement of the s	ent of E should	eficiencies and be fully identifie	Plan of Cor	ent Amendments rection, that have er the regulation o of each requirem	rLSC		
ITE	VI.		DATE	ITEM				DATE	ITEM		.,	DATE	
Y4			Y5	Y4				Y5	Y4			<b>Y</b> 5	
ID Prefix	F0164		Correction	ID Prefix	F0225	i		Correction	ID Prefix	F0228		Correction	
Reg.#	483.10(e), 483.75	(I)(4)	Completed	Reg. #	483,13 - (4)	(c)(1)(li)-(lil), (c	:)(2)	Completed	Reg.#	483.13(c)		Completed	
LSC		· · · · · · · · · · · · · · · · · · ·	04/14/2018	LSC				04/14/2018	LSC	the state of the s		04/14/2016	
ID Prefix	F0242		Correction	ID Prefix	F0246			Correction	ID Prefix	F0248		Correction	
Reg.#	483,15(b)		Completed	Reg. #	483.15	(e)(1)		Completed	Reg.#	483,15(1)(1)		Completed	
LSC			04/14/2016	LSC		<u> </u>		04/14/2016	LSC			04/14/2018	
ID Prefix	F02B2	<u> </u>	Correction	ID Prefix	F0312			Correction	ID Prefix	F0314		Correction	
Reg.#	483,20(k)(3)(li)		Completed	Reg. #	483.25	(a)(3)		Completed	Reg. #	483,25(c)		Completed	
LSC	- Annual Control of the Control of t		04/14/2016	LSC	***************************************	~~		04/14/2018	LSC	A Section of the sect		04/14/2016	
D Prefix	F0333		Correction	ID Prefix	F0354			Correction	ID Prefix	F0485		Correction	
Reg. #	483.25(m)(2)		Completed	Reg.#	483.30(	(b)		Completed	Reg.#	483.70(h)		Completed	
_SC		7	04/14/2018	LSC				04/14/2018	LSC	· · · · · · · · · · · · · · · · · · ·		04/14/2016	
D Prefix		7,000	Correction	ID Prefix	No.		*****	Correction	ID Prefix			Correction	
Reg. #			Completed	Reg. #				Completed	Reg. #			Completed	
_SC				LSC	Automorphisms				LSC	Variable Control of the Control of t			
REVIEWED		REVIEWE (INITIALS	BF/KJ	DATE 05/16/2	2016	SIGNATURE	OF SU	RVEYOR 326	13		DATE 05/0	3/2016	
REVIEWED BY DATE CMS RO (INITIALS)				TITLE			V VIII.		DATE				
FOLLOWU 2/25/2016	OLLOWUP TO SURVEY COMPLETED ON /25/2016				K FOR	ANY UNCORF	RECTED	DEFICIENCIES.	WAS A SUMI	MARY OF			

### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-
IDENTIFICATION NUMBER	A. Building			
245298 <sub>Y1</sub>	B. Wing	Y2	5/3/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - TWIN	RIVERS	305 FREMONT STREET		
		ANOKA, MN 55303		

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

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0164		Correction	ID Prefix	F0225		Correction	ID Prefix	F0226		Correction
Reg. #	483.10(e), 483.75	(I)(4)	Completed	Reg. #	483.13( - (4)	c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC			04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix	F0242		Correction	ID Prefix	F0246		Correction	ID Prefix	F0248		Correction
Reg.#	483.15(b)		Completed	Reg. #	483.15(	e)(1)	Completed	Reg. #	483.15(f)(1)		Completed
LSC			04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix	F0282		Correction	ID Prefix	F0312		Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)		Completed	Reg. #	483.25(	a)(3)	Completed	Reg. #	483.25(c)		Completed
LSC			04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix	F0333 483.25(m)(2)		Correction	ID Prefix	F0354 483.30(	b)	Correction	ID Prefix	F0465 483.70(h)		Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
REVIEWE STATE AG		REVIEWE (INITIALS)	рву BF/KJ	DATE 05/16/2	2016	SIGNATURE OF SU	JRVEYOR 326	13		DATE 05/0	03/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS)		DATE		TITLE				DATE	
<b>FOLLOW</b> ( 2/25/2010	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE				YES	s 🗆 no

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
7.1.2.2.11		.52	A. BUILDING: _		
		00866	B. WING	<del></del>	R 05/03/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN I	LIVINGCENTER - TWIN F	305 FREMO ANOKA, M	ONT STREET N 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{2 000}	Initial Comments		{2 000}		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION 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.				
	staff, visited the above correction orders are 1375 has been not be	veyors of this Department's e provider and the following issued. Licensing order en corrected. The orginal on February 25, 2016, will		On May 2-3, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued.  Please indicate in your electronic plan correction that you have reviewed the orders, and identify the date when the	se

Minnesota Department of Health

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

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
			7 50.12510		R				
		00866	B. WING		05/03/2016				
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE					
GOLDEN	305 FREMONT STREET  305 FREMONT STREET								
	OLUMBA DV OT	<u> </u>	MN 55303						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE				
{2 000}	Continued From page	e 1	{2 000}						
	In addition, a complai completed at the time survey, and an invest	nt investigation(s) were also e of the state licensing revisit igation of complaint/s 8057 were completed and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.  The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule out of complian listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the finding which are in violation of the state state after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correction and Time period for Correction and Time period for Correction Federal Deficiencies only. The WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATUTES/RULES.	the ." ce is e "To er. s ute met vors f ction. G OF				
{21375}	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	{21375}						
	home must establish	control program. A nursing and maintain an infection gned to provide a safe and							

Minnesota Department of Health

STATE FORM 6899 LZZ912 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R	
		00866	B. WING		05/03/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{21375}	Continued From page	2	{21375}			
	sanitary environment.					
	by: Uncorrected based or original licensing order	t is not met as evidenced in the following findings. The er issued on February 25, ffect. Penalty assessment				
	Based on observation, interview, and document review, the facility failed to ensure infection control protocol was followed when staff did not wear gloves during insulin administration for 3 of 5 residents (R123, R18, R40) observed during insulin administration.					
	Findings include:					
	R123's diagnoses as indicated on the quarterly Minimum Data Set (MDS) dated 4/22/16, included type 2 diabetes mellitus (metabolic disease causing increased blood glucose levels and may require insulin). Review of the physician Order Summary Report on 4/22/16 identified R123 received sliding scale Novolog insulin four times a day.					
	During observation of medication administration on 5/2/16, at 4:27 p.m., licensed practical nurse (LPN)-A primed R123's Novolog insulin pen and dialed up 8 units. LPN-A cleansed the abdomen with an alcohol wipe and injected R123's medication. LPN-A did not wash hands before or after the insulin administration, and did not wear gloves.					
		indicated on quarterly MDS ed type 2 diabetes mellitus.				

Minnesota Department of Health

STATE FORM 6899 LZZ912 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		"	
		00866	B. WING		05/0	3/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREM	ONT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{21375}	Review of the physici dated 4/5/16 identified Humalog insulin with  During observation of on 5/2/16, at 4:33 p.m Novolog pen and dial R18's abdomen with a the insulin. LPN-A dia following R18's injects wore no gloves.  R40's diagnoses, as i MDS dated 1/21/16, i mellitus. Review of th Report dated 4/5/16 in Novolog insulin on a subject of the Novolog insulin on subject of the Novolog insulin on subject of the Novolog insulin on subject of the Novolog insulin alcohol proper into R40's abdomen. Or wear gloves before administration.  During interview on 5 registered nurse (RN) manager, stated "all on gloves prior to admistrated all licensed stated all licensed stated all licensed stated in proper insulin administration.	an Order Summary Report d R40 received 3 units meals.  I medication administration in LPN-A primed R18's ed up 3 units. LPN-A wiped an alcohol wipe and injected d not wash hands before or able medication, and again, indicated on the quarterly included type 2 diabetes e physician Order Summary dentified R40 received sliding scale, before meals.  I medication administration in LPN-A attached a needle ulin pen, primed the pen, and it. LPN-A cleansed R40's inad and injected medication LPN-A did not wash hands e or after R40's insulin  I/02/2016 at 5:34 p.m., in or after R40's insulin in RN-A wiff were provided education in inistration within the last ged they had completed ach licensed staff member they were aware to use	{21375}			

Minnesota Department of Health

STATE FORM 6899 LZZ912 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00866	B. WING		05/0	3/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREMO	ONT STREET			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
{21375}	Continued From page	2 4	{21375}			
	director of nursing (Dimembers should be with the insulin administration of the director of th	/2/16 at 6:03 p.m., the ON) stated all licensed staff vearing gloves throughout tion process. The DON ng staff were tested out on hin the last couple of				
	Review of Novolog Flexpen Competency sheet dated 11/9/15, listed numerous competencies, including: "DONS clean gloves," "Removes gloves," and "performs hand hygiene." A review of the checklists indicated LPN-A completed the insulin pen competencies on 3/24/2016.					
	dated 1/13/16, directed order for blood sugar gloves 3. Follow man and care of the equip Discard used lancet in	Blood Sugar Monitoring ed: "1. Check physician testing frequency 2. Put on ufacturer's directions for use ment used in your facility 4. In sharps container 5. Check ure bleeding has stopped. Reded."				

Minnesota Department of Health

STATE FORM 6899 LZZ912 If continuation sheet 5 of 5

#### STATE FORM: REVISIT REPORT

	OTATE FORM. RE	Non Kei oki		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
00866 <sub>Y1</sub>	B. Wing	Y2	5/3/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - TWIN	RIVERS	305 FREMONT STREET		
		ANOKA, MN 55303		
				_

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

roport ioi	111).										
ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20565	(	Correction	ID Prefix	20900		Correction	ID Prefix	20920		Correction
Reg. #	MN Rule 4658.04 Subp. 3		Completed	Reg. #	MN Rule Subp. 3	e 4658.0525	Completed	Reg. #	MN Rule 4658.052 Subp. 6 B	5	Completed
LSC		(	04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix	21426	(	Correction	ID Prefix	21435		Correction	ID Prefix	21545		Correction
Reg.#	MN St. Statute 14 Subd. 3	14A.04	Completed	Reg.#	MN Rule Subp. 1	e 4658.0900	Completed	Reg. #	MN Rule 4658.132 A.B.C	0	Completed
LSC		(	04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix	21665	(	Correction	ID Prefix	21810		Correction	ID Prefix	21830		Correction
Reg. #	MN Rule 4658.14	-00	Completed	Reg. #	MN St. Subd. 6	Statute 144.651	Completed	Reg. #	MN St. Statute 144 Subd. 10	.651	Completed
LSC		(	04/14/2016	LSC			04/14/2016	LSC			04/14/2016
ID Prefix	21855	(	Correction	ID Prefix	21980		Correction	ID Prefix			Correction
Reg.#	MN St. Statute 14 Subd. 15	14.651	Completed	Reg. #	MN St. Subd. 3	Statute 626.557	Completed	Reg. #			Completed
LSC		(	04/14/2016	LSC			04/14/2016	LSC			
ID Prefix		(	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		(	Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			_	LSC			
REVIEWE STATE AC		REVIEWED (INITIALS)		DATE 05/16/2	2016	SIGNATURE OF S		2613		DATE 05/0	03/2016
REVIEWE CMS RO	D BY	REVIEWED (INITIALS)	ВҮ	DATE		TITLE				DATE	
<b>FOLLOW</b> 2/25/201	UP TO SURVEY C	OMPLETED O	DN			ANY UNCORRECTE ED DEFICIENCIES				YES	s 🗆 no

Page 1 of 1 EVENT ID: LZZ912

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: LZZ9

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

		PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY A	GENCY	F	acility ID: 00866
1. MEDICARE/MEDICAID P (L1) 245298 2.STATE VENDOR OR MED (L2) 400099400			3. NAME AND ADI (L3) GOLDEN LI (L4) 305 FREMO! (L5) ANOKA, MN	VINGCENTER - NT STREET			55303	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHAN (L9)	IGE OF OWNERSHIP		7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> (L7	7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
DATE OF SURVEY     ACCREDITATION STATU     Unaccredited     AOA	02/25/2016 US: 1 TJC 3 Other	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIF From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BR 18 SNF	56 56	5 (L18) 5 (L17) 19 SNF	X B. Not in Com	nce With quirements	n	2. Tec 3. 24 4. 7-I	chnical Personnel Hour RN Day RN (Rural SNF) Te Safety Code B* MEETS	Following Requirements:  6. Scope of Service 7. Medical Direct 8. Patient Room St 9. Beds/Room.  (L12)	tor
(L37)	56 (L38)	(L39)	(L42)	(L43)					
<ul><li>16. STATE SURVEY AGENCE</li><li>17. SURVEYOR SIGNATUR</li></ul>		PLICABLE S	SHOW LTC CANCELL  Date:	ATION DATE):		18. STATE SUI	RVEY AGENCY API	PROVAL	Date:
Michelle Th	nompson, HI	FE NE	<u>II</u> (	04/01/2016	(L19)	Kate Jo	hnsTon, Pro	ogram Specialis	04/08/2016 (L20)
	PAR	T II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	
19. DETERMINATION OF E  1. Facility is E  2. Facility is 1	ligible to Participate	(L21)		IPLIANCE WITH C	EIVIL	2.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE  OF PARTICIPATION 10/01/1985  (L24)	Е	C AGREEMI BEGINNING L41)		4. LTC AGREEME ENDING DATI  (L25)		VOLUNTARY 01-Merger, Clos		INVOLUNT 05-Fail to Mo	L30)  CARY  eet Health/Safety  eet Agreement
25. LTC EXTENSION DATE	A.	. Suspension	E SANCTIONS of Admissions: pension Date:	(L44) (L45)		03-Risk of Invol 04-Other Reason	untary Termination n for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L2:		. INTERMEDIARY/C		(L31)	30. REMARKS	·		
31. RO RECEIPT OF CMS-15			. DETERMINATION (	OF APPROVAL DAT		Posted 04/1			
	(L32	2)			(L33)	DETERMIN	(ATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2816 March 10, 2016

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, Minnesota 55303

RE: Project Number S5298027, H5298053, H5298054, & H5298055

Dear Ms. Lyon:

On February 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 25, 2016 standard survey the Minnesota Department of Health completed an investigation of complaints numbered H5298053, H5298054, & H5298055 that were found to be unsubstantiated.

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

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

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

<u>Plan of Correction</u> - 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;

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

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

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

#### DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

Fax: (320)223-7348

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 5, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 5, 2016 the following remedy will be imposed:

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

#### PLAN OF CORRECTION (PoC)

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

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

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 25, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



CMS Certification Number (CCN): 245298

#### March 21, 2016 By Certified Mail and Facsimile

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, MN 55303

Dear Ms. Lyon:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND

NOTICE OF IMPOSITION OF REMEDY

Cycle Start Date: February 25, 2016

#### STATE SURVEY RESULTS

On February 23, 2016, a Life Safety Code survey and on February 25, 2016, a health survey and complaint investigation were completed at Golden Livingcenter - Twin Rivers by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. The health survey and complaint investigation found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level F, cited as follows:

• F354 -- S/S: F -- 483.30(b) -- Waiver-Rn 8 Hrs 7 Days/wk, Full-Time Don.

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

#### FEDERAL MONITORING SURVEY

In its notice dated March 10, 2016, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by April 5, 2016. Before a revisit was conducted, however, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on March 8, 2016. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level F, cited as follows:

- K25 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K27 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

- K48 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K51 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K56 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

#### PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

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

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

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Bruce Wexelberg, Safety Engineer Centers for Medicare & Medicaid Services Division of Survey and Certification 233 North Michigan Avenue, Suite 600 Chicago, Illinois 60601-5519 Email: Bruce.Wexelberg@cms.hhs.gov

#### INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are

disputing to, Jean Ay, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for <u>all</u> cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

#### LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is May 25, 2016.

#### SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

Mandatory Denial of Payment for New Admissions effective May 25, 2016

The authority for the imposition of remedies is contained in 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

#### DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective May 25,

2016 if your facility does not achieve compliance within the required three months. This action is mandated by the Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify National Government Services that the denial of payment for all new Medicare admissions is effective on May 25, 2016. We will further notify the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective May 25, 2016.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

#### TERMINATION PROVISION

If your facility has not attained substantial compliance by August 25, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

#### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 25, 2016, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Golden Livingcenter - Twin Rivers will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2016. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

#### APPEAL RIGHTS

This formal notice imposed:

Mandatory Denial of Payment for New Admissions effective May 25, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at <a href="https://dab.efile.hhs.gov/user\_sessions/new">https://dab.efile.hhs.gov/user\_sessions/new</a> to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that <u>all</u> hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Nancy K. Rubenstein, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

#### **CONTACT INFORMATION**

If you have any questions regarding the Federal Monitoring LSC survey, please contact Bruce Wexelberg, Safety Engineer, at (312) 353-2859. Bruce Wexelberg's fax number is (443) 380-6756. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

/s/

Jean Ay
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human S

Minnesota Department of Human Services Office of Ombudsman for Older Minnesotans Stratis Health

#### Addendum to plan of correction:

#### F 164

It is the policy of Golden Living Center Twin Rivers that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. To assure continued compliance the following plan has been implemented.

Resident #8 prefers not to wear a shirt while in bed. Resident feels that the shirt is uncomfortable. Also resident prefers to have curtain and door open for comfort. To correct this situation the following plan is in place:

Resident has agreed to move to an alternate room where he will be less visible from the hall to respect his privacy and maintain his dignity to staff, visitors, and residents passing by.

Educate staff on the standard for individual respect and dignity and plan set in place to ensure R8 is provided the opportunity for personal privacy at all times.

DNS or designee will complete weekly audits to assure continued compliance with the plan until a consistent outcome that resident's dignity and privacy is being maintained. Audit will include staff interviews in regards to resident's privacy, review of visitor concerns or complaints in regards to privacy and dignity, and personal account of resident's privacy by DNS or designee.

Subsequent resident admissions to Twin Rivers who may exhibit similar behaviors will be approached in a similar manner. Numerous approaches will be attempted until a successful means of achieving the goal of having the resident's privacy and dignity ensured.

OAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compilance noted.

Date of Completion: 4/4/16

The DNS or designee is responsible for monitoring compliance.

#### F225 & F226

It is the policy of Golden Living Center Twin Rivers that potential incidents of abuse or neglect be filed with State agency immediately in accordance with federal regulation and the facility abuse prohibition policy.

Reports of financial exploitation were filed with the State agency however reports were noted not to file timely. Investigations were thoroughly completed on each incident. Staff was interviewed at the time of the reports. Employee schedules were reviewed and correlated to missing money. Police report was filed with each instance of missing money. State background checks and company background checks are completed on all new hires. Reference checks are also completed. Summaries of investigations were filed timely with the State agency. Social service presented at resident council to remind residents to keep their money locked up in their top drawer or if they are interested to open a trust account. All resident rooms have been audited and given a key to their locked drawers.

1 M/1/14 Staff will be educated on vulnerable adult policy and resident rights. Education on who to report potential incidents of abuse/neglect to immediately will be included in the education. Residents will be assessed if they are able to use the key to their locked drawer. If they are unable to use the key then they will be encouraged to deposit their money in a trust account. The assessment and presence of the key will be updated quarterly and annually. In the future, if further incidents of missing funds are discovered all previous incidents of missing money and timelines will be reviewed for potential perpetrators. Schedules will be correlated from past incidents to help determine the potential perpetrator. Identifying an exact timeline of when the money went missing is imperative. Interviewing the resident, staff, and family in regards to a timeline of when the money was last seen and when it went missing will assist in narrowing down potential perpetrators.

Executive Director or designee will monitor daily for compliance of the abuse prohibition policy and the timely/immediate reporting of abuse and neglect to the state agency.

QAPI Committee will provide direction or change when necessary based on the compliance noted.

Date of Completion: 4/4/16

The Executive Director or designee is responsible for monitoring compliance.

F 242

It is the policy of Golden Living Center Twin Rivers that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care, interact with member of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident.

Plan of correction for resident for who survey noted that the facility failed to honor the preference for waking in the morning.

Resident identified will have plan of care updated to include the preference of not getting up till later in the morning after she wakes up on her own. Staff will be educated in regards to the preference of this resident.

When assessing the preferences of new residents or long term residents they will be asked when they like to get up and go to bed. This information will become part of the plan of care and also communicated with the nursing assistants. Preferences have been taken for all in house residents. The assessment of resident preferences will be reviewed and updated quarterly and annually.

All staff will be educated on the meaning of F242 and the importance of following resident preference.

The DNS or designee will conduct weekly audits to ensure compliance with the plan of care for the resident identified in regards to waking preference. Random audits will also be completed to ensure other residents are having their preferences met.

QAPI Committee will provide direction or change when necessary based on the compliance noted.

Date of Completion: 4/4/16

DNS or designee is responsible for monitoring compliance.

F 282/314

It is the policy of Golden Living Center Twin Rivers that each resident will receive services in accordance with each resident's plan of care.

Plan of correction for resident identified:

Resident will be assisted to reposition every 2 hours per the plan of care. Staff will be educated and monitored to assure plan of care is being followed.

Education will provided to all staff in regards to the importance and need to follow the plan of care in regards to repositioning.

Resident's skin is assessed for tissue tolerance annually, upon admission, and with changes of condition. Turning and repositioning schedule is created with use of tissue tolerance assessment, review of medical condition, and review of ADL ability. Skin checks are completed weekly by licensed staff and upon admission. Skin is also monitored daily by nursing assistants with cares. If skin alterations are noted at any time the nurse manager or designee is updated and the root cause is determined. At this time after assessment the turning and repositioning schedule may be altered. Residents who are at high risk for pressure will have assessments and care plans reviewed to ensure interventions including turning and repositioning schedule are meeting resident's needs.

DNS or designee will complete weekly turning and repositioning audits to assure compliance. Once compliance is maintained audits will be completed monthly.

QAPI Committee will provide direction or change when necessary based on the compliance noted.

Date of Completion: 4/4/16

DNS or designee is responsible for monitoring compliance.

#### F 246

It is the policy of Golden Living Center Twin Rivers that each resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

Plan of correction for resident identified:

Alternative bathing options were explored for resident identified. Resident prefers to receive a shower. South unit bathing room was not an option due to area that had floor drain had electrical outlets and lights which were not waterproof. Shower option on north end was explored. Turning shower chair in different manner allows staff to get him in/out of shower without potential injury to legs. Shower is provided weekly by DNS or designee and nursing assistant.

Other residents will shower or bathe per their preference and assuring the safety of resident and staff. Resident bathing preferences have been taken for all in house residents. If concerns arise in regards to bathing DNS or designee will assist in finding alternative options and document on the plan of care.

Nursing assistants and nurses will be educated on the showering procedure for resident identified. Plan of care will updated. Resident bathing preferences will be updated quarterly and annually.

DNS or designee will monitor that shower is completed weekly per the plan of care.

QAPI Committee will provide direction or change when necessary based on the compliance noted.

Date of Completion: 4/4/16

DNS or designee is responsible for monitoring compliance.

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

WHOLE A 4/1/14

PRINTED: .03/10/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE COMP	SURVEY LETED
	•	245298	B. WING		MAR 2 2 2016	02/	25/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN F	RIVERS	•	30	TREET ADDRESS, CITY, STATE, ZIP CODE DEFREMONT STREET Dept of Health St. Cloud		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	as your allegation of Department's accepta	correction (POC) will serve compliance upon the ance. Your signature at the ge of the CMS-2567 form will	F	000	Twin Rivers objects to the allegat non-compliance in this Statemed Deficiency and deficiency was correctly cited and is to be construed as an admission interest of the facility, the administrany employees, agents or other individuals who draft or may be discussed Response or Plan of Correction. In a	also not against rator of ividuals in this	
	revisit of your facility validate that substant	cceptable POC, an on-site may be conducted to tial compliance with the attained in accordance with			preparation and submission of this Correction does not constitute an ad or an agreement of any kind by the of the truth or any facts alleged correctness of any conclusions set this allegation by the survey agency.	mission facility or the	
F 164 SS=D	and H5298055 were standard survey, and during this survey. 483.10(e), 483.75(l)(APRIVACY/CONFIDE) The resident has the	ons H5298053, H5298054 completed at the time of the were not substantiated  4) PERSONAL NTIALITY OF RECORDS right to personal privacy and or her personal and clinical	F	164	Accordingly, the facility has prepar submitted this Plan of Correction because of the requirements under St Federal law that mandate submissis plan of correction within ten days survey as a Condition of Participa Title 18 and Title 19 programs, submission of the Plan of Correction this time frame should in no	solely tate and on of a of the ation in The a within	4/4/16
	records.  Personal privacy incl medical treatment, w communications, per meetings of family ar does not require the room for each reside  Except as provided in section, the resident release of personal a individual outside the	udes accommodations, ritten and telephone	The second		considered or construed as agreeme allegations of non-compliance or adn by the facility.  F 164  It is the policy of Golden Living Twin Rivers that each resident has the to personal privacy and confidentiality or her personal and clinical record assure continued compliance the following plan has been implemented.  Resident #8 prefers not to wear a shir in bed. Resident feels that the suncomfortable. Also resident preshave curtain and door open for comformer this situation the following plan.	Center the right by of his s. To lowing the while thirt is fers to out. To	
		loes not apply when the	11	7	place:	10 111	(VE) DATE

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING		02/25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN I	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 164	resident is transferred institution; or record institution; or record institution; or record institution; or record in the facility must keep contained in the residence in the form or storage in release is required by healthcare institution; contract; or the residence institution; contract; or the residence in	d to another health care release is required by law.  confidential all information dent's records, regardless of nethods, except when a transfer to another law; third party payment ent.  is not met as evidenced  n, interview and document led to implement measures sual privacy for 1 of 1 random observations.  num Data Set (MDS)  /27/16, identified R8 was required extensive mobility, personal hygiene  /22/16, at 3:05 p.m., R8 was coom door fully open, with a om his waist down, exposing body. R8 stated he preferred recause he was too warm, omfortable. R8 stated he do to have his room door unidentified facility staff during this time, and made 3's privacy curtain to ensure	F 164	Resident has agreed to move alternate room where he will be visible from the hall to respend privacy and maintain his dign staff, visitors, and residents passing the staff on the standard individual respect and dignity and set in place to ensure R8 is provide opportunity for personal privacy times.  DNS or designee will complete we audits to assure continued composition with the plan until a consistent out that resident's dignity and privacy being maintained.  Subsequent resident admission Twin Rivers who may exhibit a behaviors will be approached similar manner. Numerous approximation will be attempted until a successful provide direct change when necessary and will dictate continuation or completion of monitoring process based on the composited.  Date of Completion: 4/4/16  The DNS or designee is responsible monitoring compliance.	ne less act his aity to ang by. ad for d plan ded the at all are acy is as a sessful anying dignity at the at the at this aliance

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WNG	B. WNG		02/25/2016	
	ROVIDER OR SUPPLIER	RIVERS		:	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)			(X5) COMPLETION DATE
F 164	in his bed with just a body, with his bare of room door was open, residents, visitors and R8's room from the h During a follow up into p.m., R8 was lying in exposing his unclothed Residents, staff and word with the door op the hallway. R8 state different room locatio more visual privacy.  During an interview of family member (FM)-"Uncomfortable," to sand would prefer R8 something else used from the hallway.  During an interview of FM-B indicated it was residents at the facility or egistered nurse (RN) a little uncomfortable dignity and his privacy.  During an interview of registered nurse (RN) a little uncomfortable dignity and his privacy.	n 2/23/16 at 2:00 p.m. lying sheet covering his lower nest exposed. The residents and could be seen by other distaff who were walking by allway.  erview on 2/23/26, at 3:58 bed with the door fully open, ed chest and abdomen. visitor were walking by R8 ben and could be seem from distance and could be seem from distance and rould be seem from distance and rould provide.  In 2/24/16, at 2:20 p.m., A stated she was see R8 partially unclothed to have clothing on, or so she would not see R8  In 2/24/16, at 2:10 p.m., a uncomfortable to see in while visiting other y.  In 2/24/16, at 3:12 p.m., and alternated, "To be honest, it's for me. I worry about his y."  In 2/24/16, at 9:16 a.m., D)-A indicated the facility had alternate interventions to	F				

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245298	B. WING_		02	/25/2016	
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN I	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 225	facility would implement residents' right to prive 483.13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPO ALLEGATIONS/INDIVENTED The facility must not a been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misappand report any knowled court of law against a indicate unfitness for other facility staff to the or licensing authoritie.  The facility must ensuinvolving mistreatment including injuries of unmisappropriation of resimmediately to the additional to other officials in accompany to the additional to the facility must have violations are thorough prevent further potent investigation is in progressentative and to with State law (including including the content of the administrator of the administrator of the administrator of the state law (including including the content of the administrator	ted 2/26/15, included the ent and monitor the ent and confidentiality.  (2)(2) - (4)  (3)  (4)  (4)  (5)(2) - (4)  (7)  (7)  (7)  (7)  (7)  (7)  (7)		It is the policy of Golden Livin Twin Rivers that potential incidents or neglect be filed with State immediately in accordance with regulation and the facility abuse propolicy.  Reports of financial exploitation we the State agency however reports we not to filed timely. Investigation thoroughly completed on each Staff was interviewed at the time reports. Employee schedules were and correlated to missing money. report was filed with each instead of missing money. State background and company background checks are also completed. Summinvestigations were filed timely and state agency.  Staff will be educated on vulnerate policy and resident rights. Educated who to report potential incide abuse/neglect to immediately wincluded in the education.  Executive Director will monit compliance of the abuse prohibition and the timely/immediate reporting of and neglect to the state agency.  QAPI Committee will provide directioning when necessary based compliance noted.	of abuse agency federal ohibition ere filed are noted in swere incident. The of the eviewed Police ance of checks are eference aries of with the evidence of with the evidence of the adult are noted in the evidence of the e	<b>त्री</b> न १७	

PRINTED: 03/10/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 245298 B. WNG 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET **GOLDEN LIVINGCENTER - TWIN RIVERS ANOKA, MN 55303** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 Continued From page 4 F 225 Date of Completion: 4/4/16 incident, and if the alleged violation is verified appropriate corrective action must be taken. The Executive Director or designee is responsible for monitoring compliance. This REQUIREMENT is not met as evidenced Based on interview and document review the facility failed to immediately report to the executive director and state agency allegations of financial exploitation for 2 of 9 residents (R97 and R12), with missing money. In addition the facility failed to thoroughly investigate 9 allegations of missing money for resident (R97, R12, R101,100,44,35,16,46 and R8). Findings include: R97's Minimum Data Set (MDS) 1/15/16 indicated she was cognitively intact. The facility Verification Of Investigation form dated 7/28/15, indicated R97 "Reported that she had written out a check to Destination Health several days prior and had been in wallet. She had 39 dollars in cash and then had 5 -\$20 bills folded and tucked in a different area in her wallet. She indicated that she looked as wanted to see that check was still there and her money was gone. No noted loss of credit cards, etc. Her key for her locked drawer was not working and she had been putting her wallet and her computer under her pillow. She had last seen her money and check on Sunday, July 26. 2015. Resident states she feels safe here." The Investigation indicated the adminstrator was informed of the incident on 7/28/16. A Incident Report-Investigative Report

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_\_ 245298 B. WNG 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **305 FREMONT STREET GOLDEN LIVINGCENTER - TWIN RIVERS ANOKA, MN 55303** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY F 225 | Continued From page 5 F 225 Submission from the facility indicated the facility did not submit the incident to the state agency until 7/30/15, two days later. During interview 2/24/16, at 3:27 p.m. with the director of social services (SW) stated she does not know why the report was submitted late and it should have been reported immediately. The SW further stated the facility did a all staff meeting on 7/30/15, after the incident because of so many resident's had missing items at the facility. During interview 2/25/16, at 1:00 p.m. the executive director (ED)-A stated she was the interim administrator and was unsure what happened with R97's allegation but it should have been immediately reported to the state agency. R12's annual MDS dated 10/16/15, indicated he was cognitively intact. The facility Verification of Investigation form dated 6/8/15, indicated "On 6/2/15 [R12] reported that he was missing \$20 (2-\$10) bills. At the time he told the social worker he thinks it might come back in the laundry as that happened before. He thought he had he money on Saturday and Sunday and noticed it was missing on Monday. He was offered a key for his locked drawer to secure the rest of his money but he declined at the time. He stated he would keep the pouch with him. On 6/7/15 he reported he was missing an additional \$9.00 from his green pouch. He stated he noticed it missing on 6/5/15 and he last saw it on 6/4/15. Room was searched for missing money and money was not located. Resident accepted key to locked drawer at this time and was encouraged to keep his green

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		245298	B. WING				02/25/2016
	ROVIDER OR SUPPLIER	RIVERS	•	305 F	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET OKA, MN 55303		
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F 225	Continued From pag	e 6°	F	225			
		ne report indicated the ED 6/9/15, seven day after the					
		of Investigation dated 6/9/15, was submitted to the state later.					
	she was waiting to s from laundry and sta	4/16, at 3:33 p.m. SW stated ee if the money came back ated "I know this incident sported immediately to the					
	stated she does not late to ED-B and sta	5/16, at 12:00 p.m. the ED-A know why this was reported the agency, the previous ED-B a facility at this time and it eported immediately.					
	Investigation reports	the facility's Verification of sindicated there were seven residnets missing money following:		THE PERSON NAMED IN COLUMN NAM			
	on 6/8/15," resident manger that he was followed up with res was \$10 or \$15. He zipper pouch that w wheelchair and he	of Investigation indicated that told the business office missing \$20. Social worker ident and he then stated it estated he had in his green as tied to the back of his also stated the lost the key to D and state agency were					
	on 7/09/15, "Report member) , nursing a	of Investigation indicated that ed to nurse that [sic] (staff ssistant registered (NAR) had te/check on her Facebook					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(XC	(X3) DATE SURVEY COMPLETED	
		245298	B. WING	B. WING		02/25/2016	
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN I	RIVERS	•	STREET ADDRESS, CITY, STATE, 305 FREMONT STREET ANOKA, MN 55303	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 225	Resident Interview Staturther indicated: "Resident Indicated: "Resident Indicated: "Resident Indicated Ind	R101] had passed away."  Jummary on the Investigation esident had expired. Social aughter, [sic], who stated eack with sentiments written if member) to have. She had aport did indicate the ED and mediately informed.  Investigation dated 7/22/15, poins in a pouch in his room. That approximately \$13 in from the pouch in residents id indicate the ED and state ately informed.  Investigation dated 7/22/15, stated R35 "Had her wallet allet and that today when corted to her it was missing." The ED and state agency formed.  Investigation dated 8/19/15, aported she was missing she usually wears and had did drawer in her room. She at her the cash on 8/14/15 her pouch several days indicate the ED and state ately informed.  Investigation dated 2/8/16, aports she had received \$50	F	225			

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RIVERS		;	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303	[ 02	20/2010
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F 225	her wallet and that too reported to her it was indicate the ED and s immediately informed  R8's Verification of Invindicated "Resident si wallet when he was a pizza and snacks sinch thought would tota he is missing approx. indicate the ED and s immediately informed  During interview 2/25, stated these incident here, and she was un stated she is worried amoney and has reimb resident for their loss police department. ED staff on 7/30/15 and 1 missing money/items. resident R68 may have the money, but was un former resident R68 dearly January. Although had been discharged additional allegations February 8, and 12, 2	day when visiting [R35] she missing." The report did tate agency were  vestigation dated 2/12/16, sated that he had \$200 in his dmitted. He purchased be he has been here which I \$35, With \$12 remaining \$148." The report did tate agency were  16, at 10:47 a.m. ED-A happened when ED-B was sure what happened. ED-A about the loss of resident ursed each of these and has called the local 2/14/15 about reporting. She suspected a former report the person taking insure. ED-A stated the ischarged in late December 19th the former resident R68 the facility had two of missing money on 1016.	F				
	Although the facility himisappropriation of re 2015 through Februar indication the facility of investigation of the mi 483.13(c) DEVELOP/ABUSE/NEGLECT, E	sident property from June y 2016, there was no completed a thorough ssing resident money. IMPLMENT	F 2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245298	B. WNG			02/	25/2016
	ROVIDER OR SUPPLIER	RIVERS		30	REET ADDRESS, CITY, STATE, ZIP CODE 15 FREMONT STREET NOKA, MN 55303	,	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by:  Based on interview, and document review the facility failed to implement their abuse prohibition policy which required immediate notification to the executive director and state agency, and thorough investigation for 9 of 9 resident (R97,R12,101,100,44,35,16,46 and 8) allegations for misappropriation of resident property.  Findings include:  The facilities POLICIES AND PROCEDURES REGARDING INVESTIGATION AND REPORTING OF ALLEGED VIOLATIONS OF FEDERAL OR STATE LAWS INVOLVING MALTREATMENT,INJURIES OF UNKNOWN SOURCE IN ACCORDANCE WITH FEDERAL AND MINNESOTA STATE VULNERABLE ADULT ACT REQUIREMENT'S revised October 2011 indicated the following: "Misappropriation- a deliberate misplacement, exploitation, or wrongful use of a resident's belongings or money without the residents consent. The wrongful use may be temporary or permanent. Exploitation included's any unauthorized expenditure of resident's fund or failure to use the resident's resources to further the best interests of the resident." The policy further indicates the report should be immediately reported to the state agency and the administrator.		F 2	226	F225 & F226  It is the policy of Golden Living C Twin Rivers that potential incidents of a or neglect be filed with State agimmediately in accordance with feregulation and the facility abuse prohib policy.  Reports of financial exploitation were	abuse gency ederal pition	नीनाक
					the State agency however reports were not to filed timely. Investigations thoroughly completed on each incistaff was interviewed at the time or reports. Employee schedules were reviand correlated to missing money. Preport was filed with each instance missing money. State background chand company background checks completed on all new hires. References are also completed. Summaric investigations were filed timely with State agency.	noted were ident. f the ewed colice e of necks are rence	
					Staff will be educated on vulnerable policy and resident rights. Educatio who to report potential incidents abuse/neglect to immediately will included in the education.  Executive Director will monitor compliance of the abuse prohibition p and the timely/immediate reporting of and neglect to the state agency.  QAPI Committee will provide directic change when necessary based on compliance noted.  Date of Completion: 4/4/16  The Executive Director or designer responsible for monitoring compliance.	n on s of be for olicy abuse on or the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245298	B. WNG_		02/25/2016	
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F 226	dated 7/28/15, indical had written out a che several days prior and had 39 dollars in case folded and tucked in She indicated that she that check was still the gone. No noted loss key for her locked drashe had been putting under her pillow. She and check on Sundal states she feels safe indicated the adminst incident on 7/28/16.  A Incident Report-Inv. Submission from the did not submit the incuntil 7/30/15, two days During interview 2/22 director of social sen not know why the repshould have been refurther stated the fact 7/30/15, after the incurrence in the second services of the second second second second services of the second se	a Set (MDS) 1/15/16 agnitively intact.  on Of Investigation form ated R97 "Reported that she ack to Destination Health ad had been in wallet. She h and then had 5 -\$20 bills a different area in her wallet. a looked as wanted to see here and her money was of credit cards, etc. Her awer was not working and her wallet and her computer had last seen her money y, July 26. 2015. Resident here." The Investigation trator was informed of the  vestigative Report facility indicated the facility cident to the state agency	F 2		·	
	interim administrator happened with R97's	5/16, at 1:00 p.m. the D)-A stated she was the and was unsure what s allegation but it should have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245298	B. WING			02/	25/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS			3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 FREMONT STREET ANOKA, MN 55303			
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F 226	Continued From page 11		F:	226			
	R12's annual MDS da was cognitively intact	ated 10/16/15, indicated he					
	6/8/15, indicated "On he was missing \$20 (and the social worker back in the laundry as thought he had he mosunday and noticed if He was offered a key secure the rest of his the time. He stated he with him. On 6/7/15 han additional \$9.00 fm stated he noticed it m saw it on 6/4/15. Romissing money and make time and was encoura pouch locked up. The	n of Investigation form dated 6/2/15 [R12] reported that 2-\$10) bills. At the time he he thinks it might come is that happened before. He oney on Saturday and it was missing on Monday. For his locked drawer to money but he declined at e would keep the pouch the reported he was missing from his green pouch. He issing on 6/5/15 and he last from was searched for money was not located. By to locked drawer at this laged to keep his green e report indicated the ED 6/9/15, seven day after the					
		of Investigation dated 6/9/15, as submitted to the state tter.					
	she was waiting to se from laundry and state	/16, at 3:33 p.m. SW stated e if the money came back ed "I know this incident ported immediately to the					
	stated she does not k	/16, at 12:00 p.m. the ED-A now why this was reported a agency, the previous ED-B					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245298	B. WING			02/	25/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS			•	3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 226	Additional review of the Investigation reports additional reports of mander that he was refollowed up with residuals \$10 or \$15. He size zipper pouch that was wheelchair and he also his drawer." The ED immediately notified.  R100's Verification of on 7/09/15, "Reported member), nursing asseposted personal note, page about resident [Resident Interview Sufurther indicated: "Reworker spoke with dashe had given the cheon it for her [sic] (staff no concerns." The restate agency were im R44's Verification of Inidicated R44 "had conspose [sic] alleges the quarters were taken from." The report dagency were immediated.	facility at this time and it corted immediately.  The facility's Verification of indicated there were seven esidnets missing money following:  Investigation indicated that fold the business office enissing \$20. Social worker lent and he then stated it estated he had in his green as tied to the back of his so stated the lost the key to and state agency were  Investigation indicated that it to nurse that [sic] (staff esistant registered (NAR) had (check on her Facebook R101] had passed away."  Jummary on the Investigation esident had expired. Social each with sentiments written if member) to have. She had port did indicate the ED and mediately informed.  Investigation dated 7/22/15, poins in a pouch in his room. The pouch in residents id indicate the ED and state in the pouch in residents id indicate the ED and state.	F	226			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245298	B. WNG			02/	25/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS			30	05 FREMONT STREET		·
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		×	,		(X5) COMPLETION DATE
indicated R16's niece with \$100.00 in her wisiting [R35] she rep The report did indicate were immediately information of Indicated "Resident responsible to the same time and that she saw it in ago." The report did agency were immediated "Resident responsible to the money was missi Investigation dated 7 niece stated R35 "Higher wallet and that to reported to her it was indicated the ED-A and immediately informed R8's Verification of Indicated "Resident services wallet when he was a pizza and snacks sin he thought would total he is missing approximation indicate the ED-A and immediately informed During interview 2/25	e stated R35 "Had her wallet vallet and that today when orted to her it was missing." te the ED and state agency ormed.  Investigation dated 8/19/15, eported she was missing she usually wears and had ad drawer in her room. She hat her the cash on 8/14/15 her pouch several days indicate the ED and state ately informed.  Investigation dated 2/8/16, eports she had received \$50 w weeks ago. She had on 2/5/16 and noticed that ng. R35's Verification of /22/15, indicated R16's ad her wallet with \$100.00 in day when visiting [R35] she is missing." The report did distate agency were d.  Investigation dated 2/12/16, stated that he had \$200 in his admitted. He purchased ce he has been here which al \$35, With \$12 remaining \$148." The report did distate agency were d.	F	226			
	Continued From page indicated R16's niece with \$100.00 in her wisiting [R35] she rep The report did indicated were immediately informed indicated "Resident in \$280 from her pouch placed it in her seconstates her son brough and that she saw it in ago." The report did agency were immediated "Resident in from her mother a few locked in her pouch the money was missil Investigation dated 7 niece stated R35 "His her wallet and that to reported to her it was indicated the ED-A and immediately informed R8's Verification of Indicated "Resident in was indicated the ED-A and immediately informed R8's Verification of Indicated "Resident in was indicated the ED-A and immediately informed R8's Verification of Indicated "Resident is wallet when he was a pizza and snacks sin he thought would totate is missing approximated informed During interview 2/25 stated these incident	CORRECTION IDENTIFICATION NUMBER:  245298  ROVIDER OR SUPPLIER	CORRECTION  245298  B. WING  ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN RIVERS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 indicated R16's niece stated R35 "Had her wallet with \$100.00 in her wallet and that today when visiting [R35] she reported to her it was missing." The report did indicate the ED and state agency were immediately informed.  R16's Verification of Investigation dated 8/19/15, indicated "Resident reported she was missing \$280 from her pouch she usually wears and had placed it in her second drawer in her room. She states her son brought her the cash on 8/14/15 and that she saw it in her pouch several days ago." The report did indicate the ED and state agency were immediately informed.  R46's Verification of Investigation dated 2/8/16, indicated "Resident reports she had received \$50 from her mother a few weeks ago. She had locked in her pouch on 2/5/16 and noticed that the money was missing. R35's Verification of Investigation dated 7/22/15, indicated R16's niece stated R35 "Had her wallet with \$100.00 in her wallet and that today when visiting [R35] she reported to her it was missing." The report did indicate the ED-A and state agency were immediately informed.  R8's Verification of Investigation dated 2/12/16, indicated "Resident stated that he had \$200 in his wallet when he was admitted. He purchased pizza and snacks since he has been here which he thought would total \$35, With \$12 remaining he is missing approx. \$148." The report did indicate the ED-A and state agency were immediately informed.  During interview 2/25/16, at 10:47 a.m. ED-A stated these incident happened when ED-B was	A BUILDING 245298  B. WING 250VIDER OR SUPPLIER  LIVINGCENTER - TWIN RIVERS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 indicated R16's niece stated R35 "Had her wallet with \$100.00 in her wallet and that today when visiting [R35] she reported to her it was missing." The report did indicate the ED and state agency were immediately informed.  R16's Verification of Investigation dated 8/19/15, indicated "Resident reported she was missing \$280 from her pouch she usually wears and had placed it in her second drawer in her room. She states her son brought her the cash on 8/14/15 and that she saw it in her pouch several days ago." The report did indicate the ED and state agency were immediately informed.  R46's Verification of Investigation dated 2/8/16, indicated "Resident reports she had received \$50 from her mother a few weeks ago. She had locked in her pouch on 2/5/16 and noticed that the money was missing. 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During interview 2/25/16, at 10.47 a.m. ED-A stated these incident happened when ED-B was	245298  245298  245298  245298  245298  245298  245298  25TREETADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MM 55303  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  indicated R16's niace stated R35 "Had her wallet with \$100.00 in her wallet and that today when visiting [R35] she reported to her it was missing."  The report did indicate the ED and state agency were immediately informed.  R46's Verification of Investigation dated 2/8/16, indicated "Resident reports she had received \$50 from her pouch on 2/6/16 and noticed that the money was missing." The report did indicate the ED and state agency were immediately informed.  R46's Verification of Investigation dated 2/8/16, indicated "Resident reports she had received \$50 from her mother a few weeks ago. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245298	B. WING		and the second s	02/	25/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS			STREET ADDRESS, CITY, STATE, ZIP CODE  305 FREMONT STREET  ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 242 SS=D	money and has reimbresident for their loss police department ab ED-A stated she had 12/14/15 about report She suspected a form been the person takin unsure. ED-A stated to discharged in late De Although the former or discharged the facility allegations of missing 12, 2016.  Although the facility his misappropriation of received the facility of investigation of the midentified in the facility 483.15(b) SELF-DET MAKE CHOICES  The resident has the schedules, and health her interests, assessinteract with members inside and outside the about aspects of his care significant to the interest of the significant to the sig	about the loss of resident bursed each of these and has called the local out the missing money. Itrained staff on 7/30/15 and sing missing money/items. It is more resident R68 may have ago the money, but was the former resident was cember early January. It is is more money on February 8, and and nine incidents of esident property from June by 2016, there was no completed a thorough issing resident money, as by policy.  ERMINATION - RIGHT TO the facility; and make choices or her life in the facility that resident.  The soft met as evidenced on, interview and document		226	F 242 It is the policy of Golden Living Color Twin Rivers that each resident has the to choose activities, schedules, and heare consistent with his or her interassessments and plans of care, interact member of the community both inside outside the facility, and make choices a aspects of his or her life in the facility are significant to the resident.  Plan of correction for resident for we survey noted that the facility failed to he the preference for waking in the morning. Resident identified will have plan of updated to include the preference of getting up till later in the morning after wakes up on her own. Staff will be educin regards to the preference of this reside	right ealth eests, with and bout that chom onor g. care not r she eated	त्तीत

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE			
F 242	choices and preference Findings include:  R50's quarterly Minim 1/15/16, indicated she and required extensiv of daily living (ADL's) grooming, bathing an  During interview on 2 stated that she does a would like to in the man  A review of R50's car indicated "I may not so needs. I do not like to further directed staff the and offer assistance a physical function deficindicated to "Encoura care plan did not indicated to "Encoura care plan did n	idents (R50) reviewed for ces.  from Data Set (MDS), dated a was moderately impaired re assistance with activities including dressing, doubteling.  //22/16, at 4:40 p.m., R50 not get to sleep in as she orning.  re plan dated 1/15/16, eek assistance for my care complain." The care plan of anticipate my care needs as needed with ADL's due to cit. The care plan also ge choices with care." The cate R50 wanted to sleep in the mead down to her chest, akfast sitting in front of her,	F	242	When assessing the preferences of residents or long term residents they wasked when they like to get up and bed. This information will become puthe plan of care and also communicated the nursing assistants.  All staff will be educated on the mean F242 and the importance of followed resident preference.  The DNS or designee will conduct waudits to ensure compliance with the putare for the resident identified in regative waking preference. Random audits will be completed to ensure other resident having their preferences met.  QAPI Committee will provide directive change when necessary based on compliance noted.  Date of Completion: 4/4/16  DNS or designee is responsible monitoring compliance.	vill be go to go to lart of d with  ing of d with  veekly lan of rds to ll also ts are  on or the	
	sleeping resident. A f removed the coffee c						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		245298	B. WING _	·	0	2/25/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS				STREET ADDRESS, CITY, STATE, ZIP CO 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 242	At 9:37 a.m., R50 waroom by nursing assibrought back to her in On 2/24/16, at 6:58 abed. At 7:05 a.m., Nand ask the resident not. R50 stated that later and NA-D left the resident likes to slee usually gets up about of R50's preference licensed practical nut conversation and state LPN-B stated that R8 night and sleep in late LPN-B and NA-D state R50 for a length of tiperference of wantin During observation 2 sleeping in bed, whe awaken up for break she didn't wish to get for a little while and the a.m. R50 was up sitt room, dressed, and coffee, and orange jus milling, eating break in her room.  During interview on 2 registered nurse (RN preference informatical questionnaire filled admission. The infor preference is utilized schedules, however	as assisted from the dining istant (NA)-A and was room.  a.m. R50 was asleep in her A-D, entered R50's room, if she would like to get up or she wanted to sleep in until ne room. NA-D stated the p in until second seating and tt 8:10-8:15 a.m. and is aware to sleep in. At this time, rse (LPN)-B joined in the sted that R50 is a "night owl". 50 prefers to stay up late at the in the morning. Both at the morning. Both at the morning in the sted that R50 is a "night owl". The sted they have worked with the and are aware of her g to sleep in.  2/24/16, at 8:33 a.m. R50 was n approached by NA-D to fast. Resident stated that the up now, and wanted to wait the tup now, and wanted to wait the tup now, and wanted to wait the sted that the room. At 9:37 ing in her wheelchair, in her seating breakfast of toast, sice. R50 was fully awake, fast, and watching television	F 2	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING		02/25/2016
	OVIDER OR SUPPLIER	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303	
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F 246 SS=D	typically passed on whave a really high turs to they get to know the encourage them to putheir coworkers. RN-honoring the resident in the morning, and care plan.  A facility policy entitle Rights, dated 2/26/15 identifies that "staff preferences, needs, integration into the recare plan."  483.15(e)(1) REASC OF NEEDS/PREFER A resident has the right services in the facility accommodations of preferences, except	sheets. This information is vith word of mouth. We don't mover of nursing assistants, heir residents and we ass this information on to A stated staff should be t choice/preference to sleep d it should be identified in the ed Preservation of Resident 5, under Resident Choice will communicate residents and choices to ensure esidents care schedule and DNABLE ACCOMMODATION RENCES	F 244		e right acility s of except lual or
	by: Based on observation review, the facility factorions for 1 of 1 restricted ifficulty accessing to the R56's quarterly Minimus R56's quarterly Mini	T is not met as evidenced on, interview and document illed to fully explore bathing sidents (R56) who had he facility bathing facility.  mum Data Set (MDS) dated intact cognition, and had sluded amputation,		Alternative bathing options were exfor resident identified. Resident prefereceive a shower. South unit bathing was not an option due to area that had drain had electrical outlets and lights were not waterproof. Shower optinorth end was explored. Turning schair in different manner allows staff him in/out of shower without poinjury to legs. Shower is provided to by DNS or designee and nursing assist	ers to room I floor which on on hower to get tential weekly

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	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE  305 FREMONT STREET  ANOKA, MN 55303  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA			(X5) COMPLETION DATE
F 246	osteoarthritis and obindicated R56 require physical assistance wasteady and only able for surface to surface revised 1/4/2016, ide deficit related to self impairments. R56's assistance of 2 using standing lift] and "end R56's care plan did not end reds/assistance for During an interview of R56 said he did not good have a shower only give me a bed be wont let me" use the restriction, but "don't shower." R56 current bath, but would prefewent on to say he was special chair, and "woth that," and then sudde [staff] talked to me at and I no longer gets received showers prefered in an interview on 2/2 nursing assistant (NA whirlpool" bath, but the of some restrictions was the shower was diffication that the talked with the "[R56] has been getting as the shower was diffication to the restriction of the restriction of the restrictions was getting a second restriction of the restricti	desity. The MDS further and extensive, two-person with transferring, was not to stabilize with assistance a transfers. R56's care plan, ntified physical functioning care and mobility care plan directed "transfer Sarah lift" [a mechanical courage choices with care." ot identify any special bathing.  In 2/22/2016 at 6:00 p.m., let to chose whether he or bath. R56 stated "They eath." R56 also said "they whirlpool because of some know why I can't use the tly receives a weekly bed in to have a shower. R56 is getting showers, using a senever had an issue with eatly "around Thanksgiving cout getting just bed baths," showers even though he had eviously.  14/2016 at 11:26 a.m., and to get a new had to change because with the tub. NA-D said R56 hower" but positioning him in cult. NA-D then stated "I he nurse" and since then and a bed bath."	F	246	Other residents will shower or bath their preference and assuring the saf resident and staff. If concerns ar regards to bathing DNS or designe assist in finding alternative option document on the plan of care.  Nursing assistants and nurses we educated on the showering proceduresident identified. Plan of care updated.  DNS or designee will monitor that showering completed weekly per the plan of care QAPI Committee will provide direct change when necessary based of compliance noted.  Date of Completion: 4/4/16  DNS or designee is responsible monitoring compliance.	Cety of rise in the will be are for the will be will be will be will be will be will be were is the will be wi	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245298	B. WING		TO THE STATE OF TH	02/	25/2016
	ROVIDER OR SUPPLIER	RIVERS		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 246	safely transfer with the The note indicated the various concerns, with (ADLs). However the R56 was changed to longer able to shower the linear and interview on 2/2 ED-A acknowledged I "bed baths" because August. The ED-A stander into the shower could not accommodated in the shower could not want the residual and needed to be into the shower becauspace. The ED states with R56 and was activations concerns.	a transfer using a lift, and was assessed to e lift and assist of 2 staff. e ED-A and R56 discussed h activities of daily living note did not identify why a bed bath, and was no	F	246			
	room with ED-A on 2/demonstrated the use the shower room. ED-moving the chair arouseated, and expresse was bathed there. At R56's shower chair in room, where the whird left side of the room haucet. There was a complete towards the was a curtain attache she "had not consider	orth unit resident shower 24/2016 at 1:40 p.m., ED-A, e of R56's shower chair in -A explained the difficulties and in the shower with R56 d her safety concerns if R56 1:59 p.m., ED-A used to the south unit bathing pool tub was located. The had a toilet, and a sink with a larain in the tile floor with the he drain. Above the drain d to the ceiling. ED-A stated red" use of the south unit elternative location for R56's					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245298	B. WING		02/2	02/25/2016	
	ROVIDER OR SUPPLIER Livingcenter - Twin i	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
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F 246	to be unsafe for R56, explore all bathing or	e 20 assessed the facility shower the facility did not fully tions, including a possible cation for R56 within the	F 24	46			
F 248 SS=D	none provided. 483.15(f)(1) ACTIVIT INTERESTS/NEEDS  The facility must provof activities designed the comprehensive a	eeds was requested, but	F 24	• Facility will increase one t	These social rt, pet sod or birector leisure	44114	
·	by: Based on observation review, the facility fail activities were provided reviewed for activities. Findings include: R4's admission Minimal 1/22/16, identified share quired assistance with The MDS activity prevery important to R4 keep up with the new participate in religiou	is not met as evidenced  n, interview and document led to ensure individualized ed for 1 of 3 residents (R4)  s.  num Data Set (MDS), dated he was cognitively intact and with activities of daily living, ference identified that it was to have reading materiel's, rs, be around animals, s services, and participate in The MDS identified that R4		hook, or puzzles). Will continue to encourage partice in group activities when approutilizing headphones if redesires.	l also ipation opriate, esident review ditional benefit will be s are citivities r each ences. mpleted ector of		

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	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN F	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 248	had a significant hea understand others bu understood.  R4's care plan, dated have much interest in I can not hear". The of to participate in my in I choose, please give The interventions include to bring in reading mathometown newspape staff of my leisure pre "sit-in" during activity join in at my own come to come in and visit we later in the day after I'me and my family recean do things togethe please help me particat my highest level.  Review of the facility I Assessment Sheet, 1, although R4 had a visit deficit, she was alert a but tires easily. The aleisure preferences of puzzles, computer/vid reading books, collect activities, parties, Bap other visit daily. R4's jindicated on assessmilling indicated in indicational note indicational mote indicational note indicational	ring deficit and was able to a was able to make herself  1/18/16, indicated " I don't joining in facility programs. goal identified, "I would like dependent activities daily as me supplies as needed." uded encourage my family terial, puzzle books, r., etc. for me, inform other ferences, invite me to programs, allowing me to fort level. invite volunteers ith me, offer me activities in finished with rehab, offer reation materials so that we reduring our visits, and pate in my favorite activities  Recreation Services (22/16, identified that ual and significant hearing and communicated clearly, assessment identified R4's casino games, bingo, eo games, television, ions, dogs, outdoor tist religion, and significant program preferences are ent form as being both th friends/family". An ed that, "resident is ure needs and significant	F 24	<ul> <li>Results will be reviewed question by the Quality Associated.</li> <li>Executive Director of designers.</li> </ul>	arterly urance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245298	B. WING _	A STATE OF THE STA		02/25/2016
	ROVIDER OR SUPPLIER	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 248	During observations in her room lying in be television on in the roor puzzles noted in the corpuzzles	on 2/23/16 4:00 p.m. R4 was bed, she did not have her com. There were no books he residents room.  .m. R4 was dressed for the g in bed. There was no books, puzzles noted in her  2/24/16 at 2:20 p.m. nursing red (R4) likes to lay in bed, comfortable and they try to om but she says "No". She to people, which is the one to do. The nurses and NA's king to her but we just do not and with her. (R4) will take as an get talking with people,  2/25/16, at 9:08 a.m. R4 ds her day in her room, in more comfortable laying on ated that she enjoys visiting a television on in her room and a white board so her nicate with her using the white on deaf.". R4 stated that she sh on her bedside table, and in latch hook". R4 stated it her to participate in group ecause, "I'm deaf, there's not	F 2	48		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245298	B. WNG		Service Control Contro	02/	25/2016
	ROVIDER OR SUPPLIER	RIVERS		305 FRI	ADDRESS, CITY, STATE, ZIP CODE EMONT STREET A, MN 55303	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 248	works the evening she with television on with not seen R4 read or activities in her room.  During interview on 2 registered nurse (RN typically go outside comfort level, and ha any other activities.  A review of the R4's Record for January 2 the following activitie (10), and Reading/W of the R4's Recreation February 2016 identicativities: TV/Radio//Reading/Writing, Puring an interview activities director (AI alternate intervention this time, R4's was how was prohibitive for instated she has tried was not interested in refuses activities that up interview at 2:25 thought volunteer has 3 times a week. Revrecords identified R4 since admission to the Although R4 spends room because of concomprehensively as determine appropria	nift and R4 is always in bed th her eyes closed. She has do other independent leisure in 2/25/16, at 8:36 a.m. with all in A. stated that R4 does not of room due to her physical as not seen R4 participate in Recreation Attendance 2016 identified participation in es; TV/Radio/Room Projects driting, Puzzles (10). A review on Attendance Record for iffed R4 participated in Room Projects (18), and	F	248			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245298	B. WNG_		A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1	02/25/2016	
	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN I	RIVERS		30	TREET ADDRESS, CITY, STATE, ZIP CODE D5 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREI			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 248 F 282 SS=D	The services provided must be provided by accordance with each care.  This REQUIREMENT by: Based on observation review the facility failed interventions for turnifollowed by staff for 1 reviewed for pressure.  R81's admission Minifollowed extensive as had not transferred or indicated he had one and one unstagable provided was length 09.1 centifoliomed and depth 02.9 cm. (If which actual depth of	dor arranged by the facility qualified persons in resident's written plan of is not met as evidenced in, interview and document ed to ensure care planing and repositioning were of 3 residents (R81) eulcers.  mum Data Set (MDS) dated was cognitively intact, sist with bed mobility and walked. The MDS stage two pressure ulcer bressure ulcer the dimension meters (cm) by width 06.7 Full thickness tissue loss in the ulcer is completely		248	It is the policy of Golden Living Center Twin Rivers that each resident will recesservices in accordance with each resider plan of care.  Plan of correction for resident identified: Resident will be assisted to reposition explant 2 hours per the plan of care. Staff will educated and monitored to assure plant care is being followed.  Education will provided to all staff regards to the importance and need to fol the plan of care in regards to repositionin Resident's skin is assessed for tistolerance annually, upon admission, with changes of condition. Skin checks completed weekly by licensed staff upon admission. Skin is also monited daily by nursing assistants with cares.  DNS or designee will complete weeturning and repositioning audits to assignee compliance. Once compliance is maintain audits will be completed monthly.	very l be n of in low g. ssue and are and ored	पीनीक
	black) in the wound b indicated he had a pro- supra pubic catheter a channel for feces to lea R81's care plan dated	essure reducing device, and a colostomy (alternative eave the body to a pouch).  I 1/26/16, indicated he had			QAPI Committee will provide direction change when necessary based on compliance noted.  Date of Completion: 4/4/16  DNS or designee is responsible	the	
	pressure ulcer of sacr	al region, paraplegia,			monitoring compliance.	101	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) D			X3) DATE SURVEY COMPLETED	
	245298	B. WING			02	/25/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN R	IVERS	•	3(	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303	, J		
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE	
bone or bone marrow) staff to provide pressu mattress, weekly wour and reposition in bed expected by the sheet) undated, indicast staff to turn and reposition. During continuous obs a.m. to 9:55 a.m. (3 how was observed to lying was slightly turned to to fis left buttock facing R81 was lying on his bounded but did not assist or off reposition. At 8:25 a.m. back watching televisic assistant (NA)-C enter him his breakfast tray of the room. She did not turning or repositioning remained on his back, for 3 decreased by the point of the positioned every two room at 6:30 a.m. he washe did not have a chahim yet, "I'm sorry".	ation and infection of the . The care plan directed re reduction/relieving and assessment and to turn every two hours.  Lets (nursing assistant care ated he was bed bound and ation every two hours.  Lervation 2/24/16, at 6:35 burs and 20 minutes) R81 in bed. At 6:35 a.m. R81 he right side only lifting part g the window. At 7:00 a.m. eack watching television. At actical nurse (LPN)- F give him his medication, for R81 to turn or a. R81 was still lying on his bon. At 9:11 a.m. nursing ed R81's room and give on his tray table, and left offer or assist R81 with g. At 9:30 a.m. R81 watching television and at ad in the same position hour and 20 minutes.  Let a 16, at 9:55 a.m. nursing de R81 should be hours and she entered his was on his right side and ance to turn or reposition	F	282				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245298	B. WNG_	77.144	İ	02/25/2016	
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		02.20.20.10	
(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 COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL CR	SHOULD BE	(X5) COMPLETI E DATE	ION
	reposition himself.  During interview 2/25, executive director (ED load himself a little burepositioning him even the care plan.  483.25(a)(3) ADL CAI DEPENDENT RESID  A resident who is una daily living receives the	/16, at 11:01 a.m. with the D) who stated R81 can off It staff should be ry two hours, as directed by RE PROVIDED FOR	F 2	It is the policy of Golden Living Twin Rivers that a resident necessary services to ma nutrition, grooming, and person hygiene.	receives intain go onal and o	ood	0
	by: Based on observation review, the facility fails completed for 1 of 3 reactivities of daily living staff for cares.  Findings include:  R90's Clinical Health 3 2/12/16, indicated the impairment, was a new Medicare 5 day sched 2/18/16, identified R9 bathing.  During an interview or	resident had no cognitive		Plan of correction for identified Resident will receive a bath we of care. Bath schedules for in be followed by nursing staff.  Bathing schedule is set for depending on resident preferer staff are to follow schedule. should be reproached if refuse shall be documented by the lice the progress notes.  All nursing staff will be trained bathing schedule and communito the licensed nurse.  DNS or designee will compresident audits to assure in received scheduled baths per sol.  QAPI Committee will provide change when necessary bas compliance noted.	all reside all reside ace. Nursi Residen ed. Refus nsed nurse to follow to icate refus alette rando resident hedule.	nts ing it's als in the als om	

PRINTED: 03/10/2016
FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MUII	TIDI E	CONSTRUCTION	T	<u>J. 0938-0391</u>
	F CORRECTION	IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		245298	B. WING			02	/25/2016
	PROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F			3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	During a follow up into a.m., R90 stated he skeep asking and noboneed a bath."  Review of the LTC (Lo Schedule identified Review of R90's med record, dated 2/1/16-2 one bath with skin che has not had a bath sin bath and skin check of During an interview or licensed practical nurs scheduled to receive hevenings. LPN-B confon 2/13/16, but there whas had a bath since to charted in the progres	erview on 2/24/16, at 11:13 till had not had a bath and "I rdy seems to connect that I ong Term Care) Bath 90 was scheduled for a bath a Saturday evening. ication administration a/29/16, identified R90 had ack which on 2/13/16, and ace. R90 should have had a an 2/20/16.  12/24/16, at 11:38 a.m., a (LPN)-B stated R90 was ais bath on Saturday armed R90 received a bath avas no indication that he an otes if R90 refused his	F	3312	Date of Completion: 4/4/16  DNS or designee is responsible monitoring compliance.	; for	
F 314 SS=D	and stated R90 did no scheduled and would in A policy for bathing was provided. 483.25(c) TREATMEN PREVENT/HEAL PRE	2/25/16, at 8:25 a.m., ) stated each resident m of one bath per week, it get his weekly bath as receive a bath today.  T/SVCS TO	F3	114	F 282/314  It is the policy of Golden Living Center Twin Rivers that each resident will receive services in accordance with each resident plan of care.	eive ent's	નીન <b>ા</b> હ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION		SURVEY PLETED	
		245298	B. WING		02	02/25/2016	
	(EACH DEFICIEN	RIVERS STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303  PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE	(X5) COMPLETION DATE	
F 314	who enters the facili does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores for this REQUIREMENT by:  Based on observative review the facility farepositioning for 1 of for pressure ulcers.  Findings include:  R81's admission Min 1/11/16, indicated he needed extensive as had not transferred indicated he had on and one unstagable measured length 09 06.7 and depth 02.9 eschar-black, brown firmly to wound bed or harder than surrofurther indicated R8 device, supra pubic (alternative channel a pouch).  R81's Care Area As 1/11/16, indicated Rulcer to his sacrum wounds promotes he	ty without pressure sores essure sores unless the condition demonstrates that ble; and a resident having ives necessary treatment and healing, prevent infection and	F 31		Staff will be assure plan of all staff in need to follow repositioning.  The definition of the desired staff and also monitored the cares.  The definition of the desired staff and also monitored the cares.  The definition of the definition of the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed on the desired staff and the direction or passed the desired staff and the desi		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING			02/	25/2016
	ROVIDER OR SUPPLIER	RIVERS		305 F	ET ADDRESS, CITY, STATE, ZIP CODE REMONT STREET KA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	The CAA further indice mattress, was immobilimited range of motio (paralysis of lower paralysis of the bone or bone of further indicated he has a ship and right buttocks ulcer to the sacrum. The provide pressure respectively wound assess reposition in bed ever assignment Sheets (rundated, indicated he were to turn and reposition of the word of turn and reposition of turn and	vacuum) to the wound site). ated he needed a special ile, had poor nutrition, n, and was a paraplegic rt of body).  I 1/26/16, indicated he had a ral region, was a paraplegia, is (inflammation and infection harrow). The care plan red pressure ulcers present, red tage two pressure ulcer to it, and a stage four pressure. The care plan directed staff reduction/relieving mattress, ment, and to turn and red two hours. R81's hursing assistant care sheet) was bed bound and staff resition every two hours.  R81's nurse practitioner redicated the patient was dedoctor and had wound vac to Continue oral antibiotic per redicated the patient was dedoctor and had wound vac redicated the patient was defect of the surface will be relieving and maintaining consistent rotation will be realing.	F	314			
	R81 was observed to R81 was observed to	lying in bed. At 6:35 a.m. be slightly turned to the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING		***************************************	02	/25/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS				3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	the window. At 7:00 abe lying on his back va.m. licensed practica observed to enter his medication, she did n 8:25 a.m. R81 was st television. At 9:11 a.r was observed to enter his breakfast tray on lurn or reposition him on his back watching was still in the same phour and 20 minutes	part of his left buttock facing a.m. R81 was observed to vatching television. At 7:55 al nurse (LPN)- F was room and give him his ot turn or reposition him. At ill lying on his back watching m. nursing assistant (NA)-C r R81's room and give him his tray table, she did not . At 9:30 a.m. R81 was still television. At 9:55 a.m. R81 position lying on his back, 3 later.	F	314			
	a.m. R81 stated he had line on his chest down move that area. R81 trapeze bar with his a but not completely off observed to grab the for 20 seconds with his morning from his able to completely lift staff had not come in day shift.  During interview 2/24 stated R81 should be hours and she entered he was on his right sic chance to turn or reposorry."	rms to lift him self slightly, of the bed. R81 was trapeze bar and lift himself is bottom slightly touching ne was able to move himself side to his back but is not himself up. R81 confirmed and repositioned him on the  116, at 9:55 a.m. (NA)-C repositioned every two d his room at 6:30 a.m. and de and she did not have a sistion him, NA-C stated "I'm					
		116, at 11:15 a.m. registered R81 should be repositioned					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING			02	/25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		72072010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page every two hours.  During observation 2/2	24/16, at 11:40 a.m. RN-A	F:	314			
	removed R81's old dra measuring his wounds pressure ulcer to his s cm x width 3.5 cm x right ischial tuberosity that measured 2.8 cm	essing and began s. R81 had a stage four acrum measuring length 5 depth 1.3. He also had a stage two pressure ulcer x 1.7 cm x .1 cm depth, e ulcer stage two 5 cm x 4.4					
	During interview 2/25/ executive director (ED himself a little, however repositioning him ever	) stated R81 can off load er, staff should be					
F 333 SS=D	as needed and tolerate consideration patient/r	position every two hours, or ed, taking into esident tolerance and e, current condition of skin. he individualized plan." NTS FREE OF	F3	333	F 333		<b>પ્</b> યા/16
		e that residents are free of			It is the policy of Golden Living Center Twin Rivers that the facility must en that residents are free of any signifi medication errors.	sure cant	
	by: Based observation, in review the facility failed (R4) was free of a pote medication error. This	is not met as evidenced terview, and document d to ensure 1 of 1 resident ential, significant had the potential to affect ve insulin administered via			Plan of correction for resident identified:  Medication error did not reach residentified. Immediate education provide nurse. Staff are to update MD/NP if they questioning if a resident received prescribed amount of medication.  MD/NP shall give further orders in reg to the medication in question.	dent ed to y are the The	

STATEMENT ( AND PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING			02/	25/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN F	RIVERS	·	3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		20,20,10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	R4's Order Summary included Humulin N S to treat diabetes) 100 subcutaneously in the During observation of on 2/22/16, at 5:13 p.r (LPN)-G attached a di Humulin insulin pen, o units and primed the r to 6 units, and entered the insulin. LPN-G pla R4's left lower abdome top of the pen to admi removing the pen, stain needle engaged." LPI North medication cart this again. There's no any [insulin]." LPN-G the medication cart, to needle, and screwed in LPN-G dialed the insuling walked down the hallow Before reaching R4's requestioned about giving LPN-G stated he was another 6 units of insuling R4 got any insulin becomes and the subcut of the sum o	fied on the Admission , included diabetes mellitus.  Report dated 2/3/16, uspension (medication used units/milliliter (ml), 6 units evening.  medication administration m. licensed practical nurse sposable needle to R4's lialed the insulin pen to 2 needle, then dialed the pen d R4's room to administer aced the insulin pen against en, pressed the button on nister the insulin, and after ted, "I'm not sure if the N-G walked back to the and stated, "I'm going to try way of telling that [R4] got went back to the drawer of ok out another disposable t on to R4's insulin pen. lin pen to 6 units, and vay toward R4's room. room, LPN-G was ag another dose of insulin. planning to administer lin because he did not feel ause he observed insulin ng the last dose. LPN-G consulting with the on duty, and after	F	333	Insulin pen competency to be comp with all licensed staff. Education provided in regards to updating the MI for further instructions if a medication potentially not received.  DNS or designee will complete rar weekly audits of insulin pen administr to ensure continued compliance with plan of correction.  QAPI Committee will provide directic change when necessary based on compliance noted.  Date of Completion: 4/4/16  DNS or designee is responsible monitoring compliance.	also D/NP was  adom ation a the  on or the	
	practitioner and were i additional dose of insu blood sugar at bedtime	nstructed to not give an lin, and to check R4's					

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE S COMPL	
		245298	B. WING			02/;	25/2016
	OVIDER OR SUPPLIER	RIVERS		305	REET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET OKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 354 SS=F	stated she would exp call or the nurse pract question as to how many received in this situated an additional dose to receiving too much in hypoglycemic (low both During interview on a executive director (Enurse practitioner if whether or not a resemedication ordered.  Review of the facility and Adverse Drug Review of the facility and Adverse Drug Review of any sign medication reaction. 483.30(b) WAIVER-FULL-TIME DON  Except when waived this section, the facility and adverse for a day, 7 days a weel Except when waived this section, the facility and the facility	2/22/16, at 5:24 p.m., RN-A pect staff to call the RN on citioner if there was any nuch insulin a resident ton, before deciding to give a prevent the resident from asulin and becoming lood sugar).  2/25/16, at 8:35 a.m., (D) stated staff should call the they were questioning ident received the amount of cition Reporting, dated the prescriber is notified ifficant error or adverse "RN 8 HRS 7 DAYS/WK, di under paragraph (c) or (d) of lity must use the services of a at least 8 consecutive hours ik.		354	F 354  Golden Living Twin Rivers has des Kimberly Bongartz, registered nurse tas the director of nursing on a fubasis.  Kimberly Lyon, LNHA, has been not the executive director.  Ongoing the facility will assure the full time director of nursing in the pool QAPI Committee will provide director change when necessary based compliance noted.	to serve all time amed as ere is a sition.	निति
		ing may serve as a charge a facility has an average daily fewer residents.			Date of Completion: 3/7/16  ED or designee is responsible for mo compliance.	nitoring	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		
		245298	B. WING			02/	25/2016
	ROVIDER OR SUPPLIER	RIVERS	•		DRESS, CITY, STATE, ZIP CODE INT STREET IN 55303	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 354	by: Based on interview of facility failed to ensure nursing (DON) was what the potential to a currently residing in the currently residing in the Findings include:  A facility job descript Services; Temporary the" General purpose assigned location in Nursing Services on position is no longer a permanent Directo coordinates and mare department. Responded to care that is consistent regulatory standards daily operations in the Director."  During entrance intee the executive director been the DON and we ED-A stated the Miniccoordinator registered as the interim DON, During interview on a registered nurse (RI	and document review, the re a full time director of vorking in the facility. This affect all 46 residents the facility.  It ion titled Director of Nursing dated 10/15/14, indicated a provides services to the absence of Director of a temporary basis until the required or has been filled by reforming Services, Plans, ages the nursing asible of the overall direction, aluation of nursing care and residents. Maintains quality and with company and absence of Executive  Triew 2/22/16, at 1:15 p.m. or (ED)-A stated she had was now the interim ED, mum Data Set (MDS) d nurse (RN)-A was acting as this time.	F	354			
		ng completion of the MDS					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WNG		14-14-14-14-14-14-14-14-14-14-14-14-14-1	02/	25/2016
	ROVIDER OR SUPPLIER	RIVERS	•	3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 FREMONT STREET ANOKA, MN 55303	*	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 354	participates in weekly meetings, weekly ber up meetings, and prodelegated by interim assistance in grievan estimated time spent between 5-10 hours promer DON (ED-A) croles of DON for the former DON, assistant (NA)-B, stat was ED-A, and had not interim DON.  During interview on 2 practical nurse (LPN) the DON, (referring to questions or concerns.  During observation of LPN-A was overheard concerns about giving NA-H to bring her conwho was the interim ID During interview 2/25 stated the DON was a coordinator (RN-A) we needed help, but if she would talk with E the interim DON).  During interview 2/25 stated the MDS coordinator (RN-A) who interim DON).  During interview 2/25 stated the MDS coordinator interview 2/25 stated the MDS coordin	oment. As the DON, she by care management havior meetings, daily stand viding assistance as ED-A including recent ce investigations. RN-A in this role as the DON was ber week, although the continues to fill most of the facility.  1/24/16, at 9:44 a.m., nursing ted the DON at the facility of identified RN-A as the 1/24/16, at 2:45 p.m. licensed -A stated she would contact to ED-A), if she had any s.  1/24/16 at 3:15 p.m. ditalking with NA-H who had gr R8 a bath. LPN-A directed incern to ED-A, and not RN-A DON.  1/16, at 11:38 a.m. LPN-F also the ED-A, and the MDS as helping ED-A when she he had any nursing concerns D-A, and not RN-A (who was 1/16, at 1:37 p.m. ED-A dinator (RN-A) continues her in addition to filling in as	F	354			
	acting DON since Oc	tober 7th 2015. RN-A helps port board to see if there is					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WNG			02/	25/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS				30	TREET ADDRESS, CITY, STATE, ZIP CODE DE FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 354	any changes, helps we depending on the were a week as the interim facility ED-B had on a indication when he wineeded to take on the for the DON position. Very busy with her rol and the DON role. 483.65 INFECTION CSPREAD, LINENS  The facility must estal Infection Control Prografe, sanitary and cort to help prevent the de of disease and infection (a) Infection Control FThe facility must estal Program under which (1) Investigates, continuinthe facility; (2) Decides what program under which (3) Maintains a record actions related to infection determines that a resprevent the spread of isolate the resident. (2) The facility must program unicable disease from direct contact will train dependent of the communicable disease from direct contact will train dependent.	with grievances, and ek, works about 5-10 hours DON. The ED-A stated the an extended leave with no ill return to his role. She e role as no one has applied ED-A stated she has been les in the facility as the ED, CONTROL, PREVENT  blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion.  Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections.  d of Infection n Control Program ident needs isolation to f infection, the facility must  prohibit employees with a se or infected skin lesions ith residents or their food, if		354	It is the policy of Golden Living Center Twin Rivers that the facility must esta and maintain an Infection Control Prodesigned to provide a safe, sanitary, comfortable environment and to prevent the development and transmissi disease and infection.  Plan of correction for identified inciden Residents identified remain free infection due to nurse not wearing per protective equipment (gloves). Educ has been completed with nurses involvincidents noted during survey.  Education will be provided to all nustaff in regards to the Infection Copolicy and the need to wear prote personal equipment when there is postentiated with blood or body fluids.  DNS or designee will complete we audits of insulin administration and I sugar checks to assure ongoing complewith Infection Control policy.  QAPI Committee will provide direction change when necessary based on	ablish ogram and help on of  ts: from esonal cation red in  arsing ontrol cetive ssible  eekly blood iance	414114

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245298	B. WING_		·	02	/25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303		20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 441	hand washing is indic professional practice.  (c) Linens Personnel must hand	ct resident contact for which ated by accepted	F4	41	Date of Completion: 4/4/16  DNS or designee is responsible monitoring compliance.	for	
	by: Based on observation review, the facility faile infection control pract of 1 resident (R49) ob	is not met as evidenced  n, interview, and document ed to ensure appropriate ices were implemented for 1 served during a blood sugar dent (R4) observed during					
	indicated diagnoses in type II, received a slid have her blood sugar.  During observation on LPN-E retrieved a bloomedication cart, enterproceeded to check he gloves. LPN-E then I the medication cart, an blood glucose machin then washed her hand.  During interview 2/25/executive director (ED	od glucose monitor from the ed R49's room, and er blood sugar with no eft R49's room, returned to not proceeded to clean the e with sanitizing wipes, and is.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245298	B. WING		0.	2/25/2016	
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	NVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 441	A facility policy titled Edated 1/13/16, directed for blood sugar testing 3. Follow manufactures care of the equipment Discard used lancet in puncture site to be sure Apply Band-Aid as net R4's diagnosis identification Record dated 1/15/16 R4's Order Summary included Humulin N S to treat diabetes) 100 subcutaneous in the education of the education.	Blood Sugar Monitoring d, "Check physician order g frequency 2. put on gloves et's directions for use and sused in your facility 4. In sharps container 5. Check re bleeding has stopped. eded."  ed on the Admission included diabetes mellitus.  Report dated 2/3/16, suspension (medication used units/milliliter (ml), 6 units evening.  medication administration medication administration medication administration medication ed units, and administer the insulin. Es, LPN-G used an alcohol of placed the insulin pension abdomen, pressed the en, held it in place for a few moved the pen. Without thygiene, LPN-G left R4's the North medication cart, r, and touched items in the g to give the next	F 44				

MAKE OF PROMIDER OR SUPPLIER  GOLDEN LYMNGCENTER - TWIN RIVERS  SIMMARY STATEMENT OF DEFICIENCIES  (X4) ID PRETIX TAG  F 441  Continued From page 39 Review of the facility's policy, Diabetes Management, Insulin Administration Competency, dated 0720/15, 18 EEROCOMM MEST are preceded by Prus. F 458  Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.  This REQUIREMENT is not met as evidenced by. Based on interview and document review, the facility failed to provide 80 sqt of froor space per resident in 8 of 28 resident rooms.  This REQUIREMENT is not met as evidenced by. Based on interview and document review, the facility failed to provide 80 sqt of froor space per resident in the or provide 80 sqt of froor space per resident in the or own should be resident bedrooms, and at least 100 square feet in single resident rooms. There is no method available to increase the size of the rooms without causing hardship on the facility failed to provide 80 sqt of froor space per resident in these rooms.  The representative review in facility failed to provide 90 sqt of froor space per resident in these rooms.  The residents resident frooms size walvers in place for rooms 4, 7, 17, 20, 21, 35 and 36, which did not meet the required minimum square footage.  The following double resident rooms did not meet	STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
GOLDEN LIVINGCENTER - TWIN RIVERS  STREET ADDRESS. CITY, STATE, 2P CODE 305 FREMONT STREET ANOKA, MN \$5303  EACH CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 441  Continued From page 39  Review of the facility's policy, Diabetes Management, Insulin Administration Competency, dated 6/28/15, directed staff to put on gloves, cleanse the injection site with an alcohol wipe, inject the insulin slowly, remove needle, remove gloves and wash hands.  F 448  823.70(g/11/iii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT  Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.  This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 sqt for floor space per resident in 8 of 28 resident rooms (room#s 4, 7, 17, 20, 21, 29, 35 and 36) which affected 14 residents (R81, R84, R34, R45, R4, R24, R64, R896, R69, R1, R8, R43, R45, R4 and R37) who currently resided in these rooms.  Findings include:  During entrance conference on 2/22/2016, at 12:50 p.m. the facility executive director (ED) stated there were resident room size waivers in place for rooms 4, 7, 17, 20, 21, 35 and 36, which did not meet the required minimum square footage.  F 441  SREMONTATION STREET ANOKA, MN \$5303  10  F 441  F 441  F 441  F 441  F 441  F 458 Bedrooms measure at least 80 sq fifversident  Golden LivingCenter-Twin Rivers would like to request a waiver under 7458 in regard to resident room size. The rooms to be included in this waiver are 4, 7, 17, 20, 21, 22, 35, and 36.  These rooms were constructed in 1962 and do not meet the current requirements for square flootage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility.  Granting this waiver would not adversely affect the residents residents residents regarding their room size.  The Director of Maintenance is responsible for the monitoring of this wa			245298	B. WING			02	/25/2016
F 441  Continued From page 39 Review of the facility's policy, Diabetes Management, Insulin Administration Competency, dated 67:26/15, directed staff to put on gloves, cleanse the injection site with an alcohol wipe, inject the insulin slowly, remove needle, remove gloves and wash hands.  F 458  Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident tooms.  This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 sq ft of floor space per resident in 8 of 28 resident rooms (room#s 4, 7, 17, 20, 21, 29, 35, and 36.)  These rooms were constructed in 1962 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility executive director (ED) stated there were resident room size waivers in place for rooms 4, 7, 17, 20, 21, 35 and 36, which did not meet the required minimum square footage.  F 441  F 458 Bedrooms measure at least 80 sq fl/resident  Golden LivingCenter-Twin Rivers would like to request a waiver under F458 in regard to resident room size. The rooms to be included in this waiver are 4, 7, 17, 20, 21, 29, 35, and 36.  These rooms were constructed in 1962 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility.  Granting this waiver would not adversely affect the residents residents residents residents residents residents residents residents regarding their room size.  The Director of Maintenance is responsible for the monitoring of this waivered requirement.			RIVERS		30	5 FREMONT STREET	<u> </u>	
Review of the facility's policy, Diabetes Management, Insulin Administration Competency, dated 6/26/15, directed staff to put on gloves, cleanse the injection site with an alcohol wipe, inject the insulin slowly, remove needle, remove gloves and wash hands.  F 458 483.70(d)(1)(ii) BEDROOMS MEASURE AT SS=B LEAST 80 SQ FT/RESIDENT  Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.  This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 sq ft of floor space per resident in 8 of 28 resident rooms (room#s 4, 7, 17, 20, 21, 29, 35 and 36) which affected 14 residents (R81, R94, R94, R96, R96, R69, R1, R8, R43, R45, R4 and R37) who currently resided in these rooms.  Findings include:  During entrance conference on 2/22/2016, at 12:50 p.m. the facility executive director (ED) stated there were resident room size waivers in place for rooms 4, 7, 17, 20, 21, 35 and 36, which did not meet the required minimum square footage.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
the required minimum square footage per resident:  Room 4 = 150 square feet, or 75 square foot per	F 458	Review of the facility's Management, Insulin dated 6/26/15, directed cleanse the injection sinject the insulin slow gloves and wash hand 483.70(d)(1)(ii) BEDF LEAST 80 SQ FT/RE Bedrooms must measible per resident in multiple least 100 square feet This REQUIREMENT by:  Based on interview a facility failed to provide resident in 8 of 28 resident in 8 of 28 residents (R81, R94, R69, R1, R8, R43, R4 currently resided in the Findings include:  During entrance confections in the facility stated there were resiplace for rooms 4, 7, did not meet the required minimum resident:	s policy, Diabetes Administration Competency, ed staff to put on gloves, site with an alcohol wipe, lly, remove needle, remove ds. ROOMS MEASURE AT SIDENT  sure at least 80 square feet de resident bedrooms, and at in single resident rooms.  is not met as evidenced and document review, the least 80 sq ft of floor space persident rooms (room#s 4, 7, 13 36) which affected 14 R34, R16, R2, R46, R96, ls, R4 and R37) who ese rooms.  erence on 2/22/2016, at executive director (ED) dent room size waivers in 17, 20, 21, 35 and 36, which ired minimum square resident rooms did not meet a square footage per			ft/resident  Golden LivingCenter-Twin Rivers welike to request a waiver under F458 in restore to resident room size. The rooms to included in this waiver are 4, 7, 17, 20, 29, 35, and 36.  These rooms were constructed in 1962 do not meet the current requirements square footage in two-bed rooms. The no method available to increase the six the rooms without causing hardship or facility.  Granting this waiver would not adver affect the residents residing in aforementioned rooms. The residenth, treatments, comfort, safety and being will be maintained at the hip possible level. Currently there are concerns or complaints from residence are garding their room size.  The Director of Maintenance is respons for the monitoring of this waiver waiver waiver waiver would not adverge affect the residents residing in a forementioned rooms. The residence will be maintained at the hip possible level. Currently there are concerns or complaints from residence are garding their room size.	yould egard o be o, 21, 2 and s for ere is ze of n the dents' well-ghest e no dents	मुमाφ

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
	,	245298	B. WNG			02/25/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN F	RIVERS		STREET ADDRESS, CITY, STATE, ZIF 305 FREMONT STREET ANOKA, MN 55303	CODE	02/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	-	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 458	resident, (R81)	e 40 re feet, or 76.2 square foot	F4	458		
	per resident, (R94 and					
	Room 20 = 150 squar resident, (R2 and R46	e feet, or 75 square foot per i)				
	Room 21 = 150 squar resident, (R96 and R6	e feet, or 75 square foot per 9)				
	Room 29 = 150 squar resident, (R1 and R8)	e feet, or 75 square foot per				
	Room 35 = 150 squar resident, (R43 and R4	e feet, or 75 square foot per 5				
To Administration of the Control of	Room 36 = 155 squar per resident, (R4 and	e feet, or 77.5 square foot R37)				
	at 3:03 p.m., "The roo not need much space, bed, a window, and it's me." R96, who also li interview at 4:36 p.m.,	n 21, stated on 2/22/2016, m is working" and he did "As long as I got TV and a s close to the bathroom for ved in room 21, stated in an it would be "nice" if the er, however, stated, "It's at is what I say."		,		
	who lived in room 7 st adequate and she had size. During Interview 6:35 p.m. stated they	I no concerns with the room v with R94 on 2/22/16 at				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245298	B. WNG			02	/25/2016		
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		3	STREET ADDRESS, CITY, STATE, ZIP CODE 105 FREMONT STREET ANOKA, MN 55303	1 02	20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ULD BE COMPLETION			
F 458	cares they needed to significant concerns.  During interview 2/22, who lived in room 4, to concerns with the rood During interview 2/25, lived in room 36 state  On 2/22/16, at 7:37 p. was observed being to using the mechanical provide adequate care appear to be an issue interviewed.  During interview on 02, R1 who stated he had of the room. WHAT R lived in room 36 states the size of his room.  R45, who lived in room 2/22/16, at 3:15 p.m. a concerns with the size R43, who also lived in on 2/22/16, 7:52 p.m., the size of their room.  R8, who lived in room 2/23/16, at 8:10 a.m. a concerns regarding the R4, who lived in room 2/23/16, at 8:10 a.m. a concerns regarding the R4, who lived in room	do and R94 had no  /16, at 6:36 p.m. with R81 hey stated they had no m size.  /16, at 9:15 a.m. R4 who d her room is small.  m. R2 who lived in room 20 ransferred into bed with staff lift. Staff were able to es and room size did not . R20 was not able to be  ///24/2016, at 1:40 p.m. with d no concerns with the size /////////////////////// at 9:51 a.m., with R37 who d he had no concerns with  m 35, was interviewed on and stated there were no e of their room.  room 35, was interviewed and had no concerns with  29, was interviewed on and stated they had no	F	458					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONST G		(X3) DATE SURVEY COMPLETED	
		245298	B. WING _		TOP/ MALE	02	/25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		305 FREM	DDRESS, CITY, STATE, ZIP CODE MONT STREET MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 458	Continued From page concerns with the size		F4	58			
	During interview on 2/ nursing assistant (NA concerns with room si and staff were able to problems.	)-B stated she had no zes in room 4 or room 7,					
	NA-G and NA-B state were difficult to mane	n 2/24/16, at 7:04 a.m., d the above named rooms uver when getting residents vever, they were able to v cares.					
	During interview on 2/ licensed practical nurs rooms were small, bu things to make it work	se (LPN)-E stated the t staff would just rearrange					
	During interview on 2/ LPN-B stated staff we cares despite the small	re able to complete resident					
	stated providing cares	24/2016, at 9:32 a.m. NA-E , especially with a hoyer lift, out we manage and have e time."					
	stated it can get tight i	4/2016, at 9:39 a.m. NA-B n R2's room when using the er, staff is able to provide					
	stated in room 29 it canneed to use a mechan	24/16, at 9:46 a.m. NA-D an be difficult because staff nical lift for the resident, to provide the necessary					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245298	B. WING		02	25/2016
	ROVIDER OR SUPPLIER	RIVERS	•	STREET ADDRESS, CITY, STATE, 305 FREMONT STREET ANOKA, MN 55303	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE)	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 458	During interview on 2 stated room 29 is "tighowever, staff had it manageable.  During interview on 2 stated the biggest chrooms, "is to give the NA-F stated staff was necessary cares.  During interview on 2 executive director (E any complaints regar	2/24/16, at 11:59 a.m. LPN-B aht" due to using a lift, arranged so it is 2/24/2016, at 2:33 p.m. NA-F allenge in working the small e resident privacy." However, s still able to provide the	F	458		
F 465 SS=E	can safely care for a room.  During interview 2/28 stated R4's room is a provide cares for her  During interview on 2 who stated although they are able to provide provide a follow up in 12:18 p.m., the ED s room waiver, and more reside in those room being accommodate 483.70(h) SAFE/FUNCTIONALE ENVIRON  The facility must provide stated in the facility must provide a room.	2/25/2016, at 9:49 a.m. NA-G R37's quarters are close, ide cares without problems. terview on 2/25/2016 at aid she will reapply for the onitor the residents who s to ensure their needs are	F	wall will be repa doors in rooms will be repaire guard will be in	will be replaced and aired in room 21, Closet 22, 24, 25, 31, and 39 d or replaced. Door stalled on the bathroom 8. Per unit supervisor,	414114

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		245298	B. WING_			02/25/2016
	ROVIDER OR SUPPLIER	N RIVERS		305	REET ADDRESS, CITY, STATE, ZIP CODE 5 FREMONT STREET IOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 465	residents, staff and This REQUIREMEI by: Based on observa review, the facility of environment in 8 or south unit which ha residents (R69, R8 R55, R87, R44, R8 whose rooms eithe closet doors; or wh disrepair; or who re dining area and ex noise; or who expri room temperatures  Findings include:  CLOSET DOORS/ R69's quarterly Mit 1/22/2016, indicate cognition.  During an interview R69 pointed out the holes at the foot or edge protector state he was not aware and stated the dist not bother me, it ju  After assisting R7 2/24/16, at approx assistant (NA)-D t	the public.  NT is not met as evidenced  tion, interview, and document failed to provide a homelike f 14 resident rooms on the ad the potential to affect 13 26, R62, R12, R71, R35, R56, B, R1, R50, R90, and R18) or lacked or had malfunctioning lose rooms were in general esided between the kitchen and pressed concerns related to lessed concerns regarding	F	465	the floor needing tiles repaire 33, not 29 — the tiles in fro dresser will be replaced. The connected to the boiler will be to control temperature. Die and equipment will be re replaced to reduce nois transporting food and dishes.  All rooms will be looked at broken and missing clos resident room and bathroof floor tiles, and wall repairs r maintenance schedule will be repair issues identified in manner.  Staff will be educated on Maintenance request and pro up of Maintenance requests. will be provided on redu levels during meal delive night.  Audits will be completed Maintenance or designee t environmental repairs need will include closet doors, red doors and bathroom door room flooring and wal Maintenance supervisor of will also be responsible for resident room temps sev weekly and making adju necessary. Audits will be weekly to determine satisfaction will temperatur level in facility.  Results will be reviewed of the Quality Assurance Com	ont of the nermostats e replaced stary carts spaired or se while to address set doors, om doors, needed. A e set up to a timely putting in oper follow Education cing noise ary and at weekly by to look for ded. This sident room rs, resident lls. The or designee monitoring veral times as e completed resident's re and noise quarterly by

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245298	B. WING		02/25/2016
	ROVIDER OR SUPPLIER L <b>ivingcenter - Twin</b> F	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
F 465	in "care tracker" [the for tracking system] and get done, sorry to say room numbers where were either off track, replaced with a curtain During environmental a.m. with maintenance following issues were Room 21, wall go with holes, wall edge Room 22, outer of Room 24, no closs Room 25, inner of Room 26, inner of Room 27, chipped tiles near resident dread Room 31, no closs Room 39, no clos	racility's maintenance stated "Evidently it doesn't "." NA-D then listed other the residents' closet doors missing, or had been no.  Itour on 2/25/2016, at 10:05 to specialist (MS) the noted:  Ruges, exposed sheet rock protector removed closet door stuck on its track set doors closet door off its track ' (inches) x 4" veneer noom door d and missing 12"x 12" floor seet doors set doors  Reset doors	F	Executive Director or design be responsible for mor compliance.      Executive Director or design be responsible for mor compliance.	

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245298	B. WNG		j	02/	25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	IVERS		STREET ADDRESS, CITY, STATE, ZIP CO 305 FREMONT STREET ANOKA, MN 55303	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 465	interim executive direct aware many of the rest non-working closet do with my team" to remostated the facility had flame-retardant mater the closet doors. ED rooms with cracked till coming off, however, place for repair, but the "At all the resident rooms."  EXCESSIVE HALLWAR R71's quarterly MDS, moderately impaired on R56's quarterly MDS, intact cognition.  R50's quarterly MDS, moderately impaired on following the evening moving a dining cart find short hall toward the notward the kitchen. The toward the kitchen was containing resident various pans used at the neared the intersection bowl and a stacked pifell out from the cart, lies and the intersection of the cart, lies award the cart the	25/2016, at 11:27 a.m. the ctor (ED) stated she was sident rooms had ors and, "has been working ove the doors. The ED been looking at using a ial for a curtain to replace stated she was aware of the e floors, and baseboards there was no current plan in e facility would be looking, ims."  AY NOISE  dated 12/31/2015, indicated tognition.  dated 1/15/2016, indicated tognition.  2/22/2016, at 7:00 p.m. meal, dietary staff was om the dining room to the nain resident hallway, and he cart was laden with food ent silverware, plates, and he meal. As the cart in of the hallways, a small e of cups tipped over and anding on the floor, bounds heard in the hallway	F	465			

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DATE SUR COMPLÉTE		
		245298	B. WING				2/25/2016
	ROVIDER OR SUPPLIER	RIVERS		305 FRI	TADDRESS, CITY, STATE, ZIP CODE EMONT STREET A, MN 55303		2/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	During interview on 2 stated that staff, "Co are." R71 stated, "I aware of." R71 stated by, staff talking, and, During interview on 2 stated staff, "talk loud the kitchen brings the "It's like a racetrack we R56 stated at least of dumped over on the the noise issue had be council meetings, but made.  During interview on 2 stated she heard noise pass by, and also	2/23/2016, at 9:15 a.m. R71 uld be more quieter than they near at lot more than staff are id she heard the lifts going "I hear the dishes going by."  2/22/2016, at 6:13 p.m., R56 d in the hallway," and when eir things to the dining room, with the dishes going by." Ince a day, "Something gets food carts." R56 also stated deen discussed at resident in no improvement had been  2/22/2016, at 4:46 p.m. R50 dees as the dishes and food fed it was noisy at night, and deep and, "I lay there and  1 2/24/2016, at 7:31 a.m. 1 A exited the kitchen door and was pushing a cart ded food trays and going to ining room. While DA-A a rhythmic sound came de cart, as if they needed oil orn. DA-A pushed the cart it rounded the corner and	F	465			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245298	B. WING			02	/25/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - TWIN I	RIVERS	- L	3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FREMONT STREET NOKA, MN 55303	1 02	125/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 465	noise from the carts, were perhaps needed would not come off the would have maintenand "Maybe they need a lead subsequent interview a new cart was just of looking to see if more the carts.  In an interview on 2/2 MS stated he, "Was to few months ago." The becarpeting in the hamuch quieter then. To looked at the carts to and uneven or if they stated he had many not to complete. The MS would also be working be looking at the carts with the noisy wheels.  In an interview on 2/2 ED stated while moving noise level is high" and complaints in the roor where the kitchen was was the residents hon staff" about the noise mindful" when moving mindful" when moving the subsequence of the state of th	dishes]." In regard to the the DM stated more tubs d, so the plates and cups e cart. The DM stated she noce look at the carts, little WD40." In a at 9:35 a.m., the DM stated rdered, and they would be bins were needed to use on 5/2016, at 10:29 a.m. the pld the carts were noisy a e MS stated there used to allway, and the carts were he MS stated he had not see if the wheels were cut just needed oiling, and naintenance requests to try stated the dietary manager of a a solution, and he would be to see what the issue is 5/2016, at 11:27 a.m., the not the food carts, "The difference were more in since and they would, "Talk to level, and, "Be more in the carts.	F	465			
	intact cognition. In an	RES  dated 12/30/2015, indicated interview on 2/22/2016, at his room was always. "way					

		I OCH OCH OCH OCES				OMB N	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
	****	245298	B. WING			0	2/25/2016
	PROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		30	REET ADDRESS, CITY, STATE, ZIP CODE 15 FREMONT STREET NOKA, MN 55303		272072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	too hot." R62 stated about how hot his roo "They are working on fan in his room becau R35's annual MDS, da intact cognition. Durin 5:43 p.m. R35 stated the winter, and she had they were aware of it.  During an environmen 10:17 a.m. with MS the temperatures were ob Main hallway, near deg. F (thermostat was Resident room #2 Resident room #3 Resident room #3 Resident room #3 Resident room #3 stated he monitored the once a week and when monitors, "More frequed did not log any of the the building, and he was a by going around the building, and he was a by going around the building area, and the had roof top units, each thermostats, and there units. The MS stated in heated by a boiler, and controls to set the heat	ne had complained to staff m was, and he was told, it." R62 stated he used a se it is so hot.  ated 1/7/2016, indicated g interview on 2/22/2016, at she felt her room was hot in ad complained to staff so at le following building served:  ar hallway to dining area: 79 se set at 73 deg F).  5 82 deg. F.  81 deg. F.  1 81 deg	F	465			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245298	B. WING			02/	25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN F	RIVERS		STREET ADDRESS, CITY, STATE, ZIP CO 305 FREMONT STREET ANOKA, MN 55303	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE
F 465	residents only covere because of the exces temperatures. The M too hot, they could op nurses to do that." The fans available for residuarm.  During interview on 2/2 Interim Executive Direct heard a complaint about talks with maintenance was the first full winter building since it had nefelt that made adjusting challenging. The ED temperature would be temperature log, and day. The ED stated if room temps, after more decrease the boiler to A facility environmentar rooms, monitoring rooms.	raintain a consistent ted he was unaware some of themselves in bed sheets sive warm room. S stated if residents were en a window, "I ask the ne MS also stated he had dents if rooms were too."  25/2016, at 11:27 a.m. the externity of the ED also stated this or the facility had to heat the ew windows installed, and not the building temperature stated her plan to monitor to implement a target a different room each of there were an increase in initoring them, they would get the temps down	F	465			

F5298024

Printed: 02/26/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245298

B. WING

02/23/2016

NAME OF PROVIDER OR SUPPLIER

#### **GOLDEN LIVINGCENTER - TWIN RIVERS**

STREET ADDRESS, CITY, STATE, ZIP CODE

#### 305 FREMONT STREET ANOKA, MN 55303

	ANOKA	A, MN 5530	03	
(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	K 000		
	FIRE SAFETY			
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 23, 2016. At the time of this survey, Golden Livingcenter Twin Rivers was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			
	This 1-story building was constructed in 1962 and was determined to be of Type II (111) construction. With an addition of the same type in 1977. It has a partial basement and is automatic sprinkler protected throughout. The facility has fire alarm detection in corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 56 and had a census of 46 at the time of the inspection.			
	The requirement at 42 CFR, Subpart 483.70(a) is MET.			
LABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	CNATURE	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 ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2816 March 10, 2016

Ms. Kimberly Lyon, Administrator Golden Livingcenter - Twin Rivers 305 Fremont Street Anoka, Minnesota 55303

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number S5298027, and Complaints Numbered H5298053, H5298054, & H5298055

Dear Ms. Lyon:

The above facility was surveyed on February 22, 2016 through February 25, 2016 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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.

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 Supervised Living Facilities.

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 is 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 first page of the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. 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 Brenda Fischer, Unit Supervisor at (320)223-7338. A written plan for correction of licensing orders is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00866	B. WING		02/25/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREM ANOKA, M	ONT STREET IN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be	innesota Statute, section on order has been issued If, upon reinspection, it is necy or deficiencies cited ed, a fine for each violation assessed in accordance es promulgated by rule of ment 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.				
	that may result from norders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.			
	the following licensing	016, surveyors of this lited the above provider and gorders were issued. In literature of survey a complaint literature of the survey and literature of the survey of t		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nurs Homes.	

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

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00866	B. WING		02/25/2016
	ROVIDER OR SUPPLIER	305 FREN	DRESS, CITY, STA	ATE, ZIP CODE	
GOLDLIA	LIVINGCENTER - IVING	ANOKA, I	MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 000	Continued From page	2 1	2 000		
	date on the bottom of marked with "Laborate Provider/Supplier Rep	oresentative's signature." orders for your records and he address below:  Unit Supervisor of Health		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule number and the corresponding text of the state statute 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 whare in violation of the state statute aft statement, "This Rule is not met as evidenced by." Following the survey findings are the Suggested Method of Correction and the Time Period For Correction.  PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATES.	e e/rule  inich er the fors f  G OF
2 565	MN Rule 4658 0405 9	Subp. 3 Comprehensive	2 565	STATUTES/RULES.	
2 303	Plan of Care; Use	ошр. о Сотпртенензіче	2 303		
		nprehensive plan of care ersonnel involved in the			
	This MN Requirement	t is not met as evidenced			

Minnesota Department of Health

STATE FORM 6899 LZZ911 If continuation sheet 2 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or doring of the state of the s	BENTI TOATION NOMBER.	A. BUILDING:	A. BUILDING:		LETED
		00866	B. WING		02	/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	ATE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	REMONT STREET			
			KA, MN 55303	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 2	2 565			
	review the facility faild interventions for turning followed by staff for 1 reviewed for pressure					
	Findings include:					
	R81's admission Minimum Data Set (MDS) dated 1/11/16, indicated he was cognitively intact, needed extensive assist with bed mobility and had not transferred or walked. The MDS indicated he had one stage two pressure ulcer and one unstagable pressure ulcer the dimension was length 09.1 centimeters (cm) by width 06.7 and depth 02.9 cm. (Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough and/or eschar (tan, brown or black) in the wound bed). The MDS further indicated he had a pressure reducing device, supra pubic catheter and a colostomy (alternative channel for feces to leave the body to a pouch).					
	pressure ulcer of sact osteomyelitis (inflamm bone or bone marrow staff to provide pressi	mation and infection of the v). The care plan directed ure reduction/relieving and assessment and to turn				
	sheet) undated, indic staff to turn and repos	neets (nursing assistant care cated he was bed bound and sition every two hours.  Servation 2/24/16, at 6:35				
	a.m. to 9:55 a.m. (3 h was observed to lying	ours and 20 minutes) R81 g in bed. At 6:35 a.m. R81 the right side only lifting part				

Minnesota Department of Health

STATE FORM 6899 LZZ911 If continuation sheet 3 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 02/20/2010
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	ONT STREET		
04.0.1=	CLIMMA DV CT	ANOKA, N		PROVIDER'S PLAN OF CORRECTION	N 0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 565	Continued From page	e 3	2 565		
	R81 was lying on his 7:55 a.m. licensed preentered his room and but did not assist or or reposition. At 8:25 a.r back watching televis assistant (NA)-C enter him his breakfast tray the room. She did not turning or repositionir remained on his back 9:55 a.m. R81 remain lying on his back, for During interview 2/24 assistant (NA)-C state repositioned every twoom at 6:30 a.m. he	m. R81 was still lying on his ion. At 9:11 a.m. nursing ared R81's room and give on his tray table, and left of offer or assist R81 with ag. At 9:30 a.m. R81 watching television and at ned in the same position 3 hour and 20 minutes.			
	During interview 2/24/16, at 11:15 a.m. with registered nurse (RN)-A stated R81 should be repositioned every two hours, and was unable to reposition himself.				
	executive director (EI load himself a little bu	/16, at 11:01 a.m. with the D) who stated R81 can off at staff should be ry two hours, as directed by			
	The director of nursin develop and impleme to ensure that resider provide staff education	THOD FOR CORRECTION: g (DON) or designee could int policies and procedures it care plans are implement; in; develop monitoring insure ongoing compliance.			

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00866	B. WING		02/25/2016	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
001		305 FREI	MONT STREET			
GOLDEN	LIVINGCENTER - TWIN F	RIVERS ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPL	ETE.
2 565	Continued From page	e 4	2 565			
	Report the findings to the Quality Assurance Committee.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty one				
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	2 900			
	Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that:	ent assessment, the director oust coordinate the				
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical				
	receives necessary t	o has pressure sores creatment and services to went infection, and prevent loping.				
	by: Based on observation review the facility faile	n, interview, and document ed to provide timely 3 residents (R81) reviewed				
	Findings include:					
	1/11/16, indicated he	imum Data Set (MDS) dated was cognitively intact, sist with bed mobility, and				

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/2	5/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREM ANOKA, N	ONT STREET IN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	and one unstagable preasured length 09.106.7 and depth 02.9 deschar-black, brown of firmly to wound bed of or harder than surrour further indicated R81 device, supra pubic condition (alternative channel for a pouch).  R81's Care Area Asset 1/11/16, indicated R8 ulcer to his sacrum ar wounds promotes head pressure wound there a negative pressure (as The CAA further indicated range of motion (paralysis of lower parallel sacrum and had osteomyelitis of the bone or bone of further indicated he had so the sacrum. The provide pressure reweekly wound assess reposition in bed ever Assignment Sheets (rundated, indicated he were to turn and reposition or had reposition of turn and reposition of turn and reposition of turn and reposition of turn and reposition or had been and the sacrum.	stage two pressure ulcer, which centimeters (cm) by width centimeters and the softer and the same tend to	2 900			

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREMO ANOKA, M	ONT STREET N 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
2 900	followed by the wound in place. Staff were to wound care, and had granulation tissue filling. Underlying disease con paraplegia, and nonconterapy will need to make the properties of the place of	indicated the patient was didoctor and had wound vac of Continue oral antibiotic per a sacral ulcer with a gin and no exposed bone. In ompliance, and medical maximize for best outcomes der. The surface will be relieving and maintaining consistent rotation will be realing.  Servation on 2/24/16, at (3 hours and 20 minutes) lying in bed. At 6:35 a.m. be slightly turned to the part of his left buttock facing a.m. R81 was observed to watching television. At 7:55 all nurse (LPN)- F was room and give him his of turn or reposition him. At ill lying on his back watching m. nursing assistant (NA)-C or R81's room and give him his tray table, she did not . At 9:30 a.m. R81 was still television. At 9:55 a.m. R81 position lying on his back, 3 later.	2 900			
	line on his chest down move that area. R81 trapeze bar with his a but not completely off	ad no feeling from his nipple  n, and he was unable to stated he can use the rms to lift him self slightly, of the bed. R81 was trapeze bar and lift himself				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREM ANOKA, N	ONT STREET IN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 900	for 20 seconds with he the bed. R81 stated he this morning from his able to completely lift staff had not come in day shift.  During interview 2/24/stated R81 should be hours and she entered he was on his right side chance to turn or reposorry."  During interview 2/24/nurse (RN)-A stated Fevery two hours.  During observation 2/removed R81's old draw measuring his wounds pressure ulcer to his second x width 3.5 cm x right ischial tuberosity that measured 2.8 cm and a left hip pressure cm with no depth.  During interview 2/25/executive director (ED himself a little, howev repositioning him ever as needed and tolerate consideration patient/choice, tissue tolerance.	is bottom slightly touching he was able to move himself side to his back but is not himself up. R81 confirmed and repositioned him on the repositioned every two do his room at 6:30 a.m. and de and she did not have a position him, NA-C stated "I'm registered resident and began are sacrum measuring length 5 depth 1.3. He also had a restage two pressure ulcer at x 1.7 cm x .1 cm depth, a ulcer stage two 5 cm x 4.4 responsitioned responsitioned responsitioned resident re	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00866		B. WING		02/2	E/2046
						02/2	5/2016
NAME OF P	ROVIDER OR SUPPLIER			ESS, CITY, STAT NT STREET	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	NOKA, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	900 Continued From page 8			2 900			
	The director of nursin develop and impleme to ensure that resider pressure ulcers receivstaff as appropriate; t systems or audit to en and report the finding Committee.	THOD FOR CORRECTION: g (DON) or designee could ent policies and procedures hts with current or at risk for ve timely services; educate hen develop monitoring hsure ongoing compliance s to the Quality Assurance CORRECTION: Twenty one	r •				
2 920	MN Rule 4658.0525	Subp. 6 B Rehab - ADLs		2 920			
	Subp. 6. Activities of comprehensive reside home must ensure th B. a resident who is activities of daily living	daily living. Based on the ent assessment, a nursing at: s unable to carry out g receives the necessary good nutrition, grooming,					
	by: Based on observation review, the facility fail completed for 1 of 3 nactivities of daily living staff for cares.  Findings include:  R90's Clinical Health 2/12/16, indicated the impairment, was a ne	resident had no cognitive					

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02	2/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN I	RIVERS	EMONT STREET			
040.45	CLIMMADY CT		, MN 55303	DDOVIDEDIS DI AN OF	CORRECTION	0/50
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From page	e 9	2 920			
	2/18/16, identified Rebathing.	90 was totally dependent for				
		n 2/22/16 at 7:00 p.m., R90 because he had not had a				
	a.m., R90 stated he s	erview on 2/24/16, at 11:13 still had not had a bath and "I ody seems to connect that I				
	Review of the LTC (L Schedule identified R one time per week, o	90 was scheduled for a bath				
	record, dated 2/1/16- one bath with skin ch	dication administration 2/29/16, identified R90 had eck which on 2/13/16, and nce. R90 should have had a on 2/20/16.				
	licensed practical nur scheduled to receive evenings. LPN-B con on 2/13/16, but there has had a bath since charted in the progres	firmed R90 received a bath was no indication that he then. Staff should have so notes if R90 refused his was no indication in the				
	executive director (EI should have a minimuland stated R90 did no scheduled and would	n 2/25/16, at 8:25 a.m., D) stated each resident um of one bath per week, ot get his weekly bath as receive a bath today.  Pas requested, but none was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	02/23/2010
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREM	ONT STREET IN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 920	2 920 Continued From page 10		2 920		
24275	The DON or designed as necessary the police regarding the need for the DON or designed for all appropriate star procedures. The DON monitor to assure all radequate and appropriate and appropriate and appropriate star procedures. The DON monitor to assure all radequate and appropriate star procedures and appropriate star procedures.	r assistance with bathing. e (s) could provide training ff on these policies and N or designee (s) could residents are receiving riate care.  CORRECTION: Twenty-one	24275		
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375		
	by: Based on observation review, the facility fail infection control pract of 1 resident (R49) obcheck, and 1 of 1 resi insulin administration. Findings include: R49's medication admindicated diagnoses in type II, received a slice	t is not met as evidenced  a, interview, and document ed to ensure appropriate ices were implemented for 1 beerved during a blood sugar dent (R4) observed during  ministration record (MAR) including diabetes mellitus ling scale insulin, and was to checked three times a day.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN I	LIVINGCENTER - TWIN F	RIVERS 305 FREM	IONT STREET IN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICE DEFICIENCY)	D BE COMPLETE
21375	LPN-E retrieved a blomedication cart, enterproceeded to check highoves. LPN-E then the medication cart, a blood glucose maching then washed her hand.  During interview 2/25 executive director (EU directed staff to wear sugars, and LPN-E states of the equipment	n 2/24/16, at 6:38 a.m. and glucose monitor from the red R49's room, and her blood sugar with no left R49's room, returned to and proceeded to clean the ne with sanitizing wipes, and ds.  /16, at 1:40 p.m. the D) stated the facility policy gloves when checking blood hould have worn gloves.  Blood Sugar Monitoring ed, "Check physician order g frequency 2. put on gloves er's directions for use and to used in your facility 4. In sharps container 5. Check are bleeding has stopped. Seeded."  itied on the Admission of the Admission o	21375		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SUR COMPLETE		
7,110 1 27,111	or contraction	IDENTIFICATION NOMBER.	A. BUILDING:		J JOHN EETE	
		00866	B. WING		02/25/2	2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
GOLDEN	GOLDEN LIVINGCENTER - TWIN RIVERS  305 FREI					
	OLIMANA DV. OT	ANOKA, N		DDO//DEDIG DI AN OF CODDECTIO	.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21375 Continued From page 12		21375				
	performing any hand room, walked back to	moved the pen. Without hygiene, LPN-G left R4's the North medication cart, er, and touched items in the ag to give the next				
During interview on 2/25/16, at 8:35 a.m. ED stated gloves should be worn when administering insulin.						
	Review of the facility's policy, Diabetes Management, Insulin Administration Competency, dated 6/26/15, directed staff to put on gloves, cleanse the injection site with an alcohol wipe, inject the insulin slowly, remove needle, remove gloves and wash hands.					
	The director of nursin and revise the policy infection control conc medications, use of g system could be deve	lucometer. A monitoring eloped to ensure staff are rected and report the results				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 3 Tuberculosis rol	21426			
	maintain a comprehe infection control progreurrent tuberculosis in	provider must establish and nsive tuberculosis ram according to the most nfection control guidelines States Centers for Disease				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN LIVINGCENTER - TWIN RIVERS			ONT STREET N 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21426	Morbidity and Mortalit This program must in infection control plan unpaid employees, co residents, and volunte Health shall provide to regarding implementa	on (CDC), Division of ion, as published in CDC's by Weekly Report (MMWR). Clude a tuberculosis that covers all paid and portractors, students, eyers. The Department of eachnical assistance ation of the guidelines.	21426		
	by: Based on interview an agency failed to ensure residents (R4) had a stest (TST) administer failed to ensure 2 of 6 a tuberculosis (TB) sycompleted upon admiguidelines.  Findings include: R4 was admitted to the medical record lacked the second step TST tuberculosis symptom.  During an interview of director of nursing (December 1) and the second step TST tuberculosis symptom.	ne facility on 1/15/16 and the documentation of receiving or having completed the a screening upon admission.  In 2/24/16, at 2:30 p.m.,  ON) stated R4 was			
	transferred from anot	ON) stated R4 was her facility and had received hat facility, but did not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - TWIN R	305 FREMORIVERS ANOKA, M	ONT STREET IN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21426	symptom screening uses required.  R8 was admitted to the medical record lacked completed TB symptos admission as required.  During an interview of DON verified R8's TB was blank and was not admission. DON states should have completed.  Review of the facility's Exposure Control Planadmissions will receive administered upon admissions will receive administered upon admissessing for signs and SUGGESTED METHOM. The administrator, directive and revise polisurveillance. The administrator, could monito to ensure ongoing continued to the surveillance of the surveillance. The administrator of the surveillance of the surveillance of the surveillance. The administrator of the surveillance	ep TST or complete the TB pon admission to this facility  the facility on 1/14/16. The I documentation of a the screening upon I per State guidelines.  In 2/24/16, at 2:34 p.m., symptom screening form of completed upon ad, "The admitting nurse and this."  Is policy, Tuberculosis In, undated, included all new the a 2-step TST to be mission, as well as and symptoms of TB.  INDD FOR CORRECTION: the sector of nursing, could dies and procedures for TB ministrator, director of r resident and TB screening	21426		
21435	home must provide ar recreation program.	General requirements. A nursing an organized activity and	21435		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	CONSTRUCTION		SURVEY PLETED	
7.1127 27.11	or dorate of the transfer of t	BEITH 10/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01/11/01		A. BUILDING: _			
		00866		B. WING		02	/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STR	REET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS		NT STREET			
			OKA, MI	N 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21435	Continued From page	e 15		21435			
	well-being of each rescomprehensive reside comprehensive plan of 4658.0400 and 4658 provided opportunities	of care required in parts .0405. Residents must be	e				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 3 residents (R4) reviewed for activities.						
	Findings include:						
	1/22/16, identified sh required assistance were the MDS activity preference in many participate in religious her favorite activities.	num Data Set (MDS), dated be was cognitively intact and with activities of daily living. If the ference identified that it was to have reading materiel's, s, be around animals, as services, and participate in The MDS identified that R4 ring deficit and was able to the was able to make herself	i s				
	have much interest in I can not hear". The of to participate in my in I choose, please give The interventions include to bring in reading machometown newspape	1/18/16, indicated " I don't in joining in facility programs. I would like dependent activities daily as me supplies as needed." I would encourage my family aterial, puzzle books, ir, etc. for me, inform other eferences, invite me to					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	,
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	IONT STREET		
	I	ANOKA, M	MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
21435	Continued From page	e 16	21435		
	join in at my own com to come in and visit w later in the day after I me and my family red can do things togethe	programs, allowing me to nfort level. invite volunteers vith me, offer me activities 'm finished with rehab, offer creation materials so that we er during our visits, and cipate in my favorite activities			
	deficit, she was alert but tires easily. The a leisure preferences or puzzles, computer/vioreading books, collect activities, parties, Bay other visit daily. R4's indicated on assessme "independent" and "wadditional note indicate independent with leistother is here daily associated by a service or puzzles noted in the Control of the C	/22/16, identified that sual and significant hearing and communicated clearly, assessment identified R4's f casino games, bingo, deo games, television, tions, dogs, outdoor otist religion, and significant program preferences are nent form as being both with friends/family". An ted that, "resident is ure needs and significant sisting with supplies."  on 2/23/16 4:00 p.m. R4 was ed, she did not have her form. There were no books he residents room.  m. R4 was dressed for the g in bed. There was no books, puzzles noted in her			
	assistant (NA)-F state because she is more	/24/16 at 2:20 p.m. nursing ed (R4) likes to lay in bed, comfortable and they try to m but she says "No". She			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
00866	B. WING _		02/25/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY	, STATE, ZIP CODE	, 32.20.20.0
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STRE ANOKA, MN 55303	ET	
(X4) ID SUMMARY STATEMENT OF DEFICIENC PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PREFIX	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETE DITHE APPROPRIATE DATE
really enjoys talking to people, which is a thing she really likes to do. The nurses a try to spend time talking to her but we juth have the time to spend with her. (R4) with much time as she can get talking with people she loves it.  During interview on 2/25/16, at 9:08 a.m. stated that she spends her day in her robed because she is more comfortable lather right side. R4 stated that she enjoys with others and has a television on in he with closed caption and a white board so visitors can communicate with her using board, because "I am deaf.". R4 stated the watches her gold fish on her bedside tather "sister is brining in latch hook". R4 should be difficult for her to participate in activities at facility because, "I'm deaf, the much" and was more comfortable in bed.  During interview on 2/24/16, at 2:45 p.m. licensed practical nurse (LPN)-A stated remains in room, even for meals and eate eating her meals in bed. LPN-A further shorts works the evening shift and R4 is always with television on with her eyes closed. In not seen R4 read or do other independent activities in her room.  During interview on 2/25/16, at 8:36 a.m. registered nurse (RN)- A, stated that R4 typically go outside of room due to her promfort level, and has not seen R4 partiany other activities.  A review of the R4's Recreation Attenda Record for January 2016 identified partic the following activities; TV/Radio/Room (10), and Reading/Writing, Puzzles (10)	and NA's st do not ll take as expole,  an. R4 om, in hying on so visiting er room to her the white that she ble, and tated it group here's not d.  an., that R4 ts in her, stated she is in bed She has ent leisure  an. with the does not shysical cipate in here cipation in Projects		

Minnesota Department of Health

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  305 FREMONT STREET  ANOKA, MN 55303   CALL DESCRIPTION STATEMENT OF DESCRIPTIONS ANOKA, MN 55303  CALL DESCRIPTION STATEMENT OF DESCRIPTIONS ANOKA, MN 55303  21430  CONTINUED STATEMENT OF DESCRIPTIONS ANOKA, MN 55303  21435  CONTINUED STATEMENT OF DESCRIPTIONS OF DESCRIPTIONS OF DESCRIPTIONS OF DESCRIPTION OF DESCRIPTION OF LIGHT OF THE APPROPRIATE DESCRIPTION OF DESCRI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL		
CALIDER LIVINGCENTER - TWIN RIVERS   305 FREMONT STREET ANOKA, MN 65303   PROVIDER'S PLAN OF CORRECTION (PARTY TAGE MENT OF DEPICIENCIES BY FULL PREFIX TAGE (PARTY TAGE MENT OF DEPICIENCIES BY FULL PREFIX TAGE (PARTY TAGE MENT OF DEPICIENCIES BY FULL PARTY TAGE (PARTY TAGE MENT OF DEPICIENCY)   PREFIX TAGE (PARTY TAGE MENT OF DEPICIENCY)   PREFIX TAGE (PARTY TAGE MENT OF DEPICIENCY)   PREFIX TAGE (PARTY TAGE MENT OF THE APPROPRIATE DEPICIENCY)    21435   Continued From page 18			00866	B. WING		02/2	5/2016
CALID   CALI	NAME OF PI	ROVIDER OR SUPPLIER			TE, ZIP CODE		
PREFEX TAG PROPRIETIVE AND STATE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  21435  Continued From page 18  of the R4's Recreation Attendance Record for February 2016 (dentified R4 participated in activities: TV/Radio/Rom Projects (18), and Reading/Writing, Puzzles (18).  During an interview on 2 /25/16 at 12:34 p.m., activities director (AD), stated that she had tried alternate interventions for activities, however, at this time, R4's was having some discomfort which was prohibitive for interacting with others. AD stated she has tried using the computer but R4 was not interested in doing this and frequently refuses activities that are offered. During a follow up interview at 2:25 p.m. the AD stated she thought volunteer had provided 1:1 visit with R4, 3 times a week. Review of the volunteer activity records identified R4 had received no 1:1 visits since admission to the facility in January 2016.  Although R4 spends almost of her time in her room because of comfort, the facility has not comprehensively assessed her needs to determine appropriate activity for R4. R4 was to have volunteer visits three times a week, but has not received any of these 1:1 visits since admission to the facility.  SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each resident are assessed and activity preferences are honored, and then audit to ensure this is occurring. Results of these audits could then be	GOLDEN	LIVINGCENTER - TWIN F	RIVERS				
of the R4's Recreation Attendance Record for February 2016 identified R4 participated in activities: TV/Radio/Room Projects (18), and Reading/Writing, Puzzles (18).  During an interview on 2 /25/16 at 12:34 p.m., activities director (AD), stated that she had tried alternate interventions for activities, however, at this time, R4's was having some discomfort which was prohibitive for interacting with others. AD stated she has tried using the computer but R4 was not interested in doing this and frequently refuses activities that are offered. During a follow up interview at 2:25 p.m. the AD stated she thought volunteer had provided 1:1 visit with R4, 3 times a week. Review of the volunteer activity records identified R4 had received no 1:1 visits since admission to the facility in January 2016.  Although R4 spends almost of her time in her room because of comfort, the facility has not comprehensively assessed her needs to determine appropriate activity for R4. R4 was to have volunteer visits three times a week, but has not received any of these 1:1 visits since admission to the facility.  SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each resident are assessed and activity preferences are honored, and then audit to ensure this is occurring. Results of these audits could then be	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435	of the R4's Recreation February 2016 identificativities: TV/Radio/R Reading/Writing, Puzzi During an interview of activities director (AD alternate interventions this time, R4's was hawas prohibitive for intestated she has tried united was not interested in refuses activities that up interview at 2:25 puthought volunteer had 3 times a week. Reviewed records identified R4 since admission to the Although R4 spends are room because of common comprehensively assed determine appropriate have volunteer visits to not received any of the admission to the facility of the supplementation of the suppl	n Attendance Record for ied R4 participated in oom Projects (18), and zles (18).  n 2 /25/16 at 12:34 p.m., ), stated that she had tried is for activities, however, at aving some discomfort which eracting with others. AD sing the computer but R4 doing this and frequently are offered. During a follow in. the AD stated she is provided 1:1 visit with R4, and the volunteer activity had received no 1:1 visits are facility in January 2016.  The facility in January 2016.  The fort, the facility has not activity for R4. R4 was to there times a week, but has ese 1:1 visits since try.  OD OF CORRECTION: The train all staff to ensure each if and activity preferences in audit to ensure this is these audits could then be y assurance meetings.	21435			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	02/23/2010
NAIVIE OF F	ROVIDER OR SUFFLIER		ONT STREET	ile, zir Gobe	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS ANOKA, M			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21545	1545 Continued From page 19		21545		
21545	MN Rule 4658.1320 A	A.B.C Medication Errors	21545		
	percent as described Guidelines for Code of 42, section 483.25 (m) the State Operations Surveyors for Long-Trincorporated by refere purposes of this part, (1) a discrepance prescribed and what administered to reside (2) the administred to reside error. A significant m (1) an error who discomfort or jeopard safety; or (2) medication requires the medication requires the medication precipitate a reoccurred toxicity. All medication prescribed. An incide error report must be final toccurs. Any significant or the physician or the physician or the physician or the physician or the reside designated represent must be made in the C. All medication prescribed. An incide report must be filed for	error rate is less than five in the Interpretive of Federal Regulations, title of Manual, Guidance to the error Facilities, which is tence in part 4658.1315. For a medication error means: by between what was medications are actually tents in the nursing home; or ation of expired of			

Minnesota Department of Health

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SU COMPLE	
		00866	B. WING		02/2	5/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE	·	
NAME OF T	NOVIDEN ON 3011 EIEN		EMONT STREET	, ZII GODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	, MN 55303			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21545	Continued From page	e 20	21545			
	resident or the reside designated represent	ician's designee and the				
	by: Based observation, ir review the facility faile (R4) was free of a po medication error. This	nterview, and document ed to ensure 1 of 1 resident tential, significant is had the potential to affect eive insulin administered via				
	_	fied on the Admission 5, included diabetes mellitus.				
		Suspension (medication used units/milliliter (ml), 6 units				
	on 2/22/16, at 5:13 p. (LPN)-G attached a dependent of the to 6 units, and entered the insulin. LPN-G pl. R4's left lower abdom top of the pen to admiremoving the pen, staneedle engaged." LF North medication card this again. There's not any [insulin]." LPN-G	f medication administration m. licensed practical nurse lisposable needle to R4's dialed the insulin pen to 2 needle, then dialed the pen d R4's room to administer aced the insulin pen against nen, pressed the button on inister the insulin, and after ated, "I'm not sure if the PN-G walked back to the t and stated, "I'm going to try to way of telling that [R4] got G went back to the drawer of took out another disposable				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00866	B. WING		02	2/25/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN R	STREET A 305 FRE	DDRESS, CITY, STATI MONT STREET MN 55303	E, ZIP CODE	, ,		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
LPN-G dialed the insuwalked down the hally Before reaching R4's questioned about givin LPN-G stated he was another 6 units of insuR4 got any insulin becon R4's skin when giv was questioned about registered nurse (RN) discussing with RN-A, practitioner and were additional dose of insublood sugar at bedtim  During interview on 2/stated she would expecall or the nurse pract question as to how more received in this situatian additional dose to receiving too much insuppoglycemic (low bloom During interview on 2/executive director (ED nurse practitioner if the whether or not a reside medication ordered.  Review of the facility's and Adverse Drug Real 10/07, included, "The promptly of any signification reaction."	it on to R4's insulin pen.  Ilin pen to 6 units, and  way toward R4's room.  room, LPN-G was  ing another dose of insulin.  planning to administer  Ilin because he did not feel  cause he observed insulin  ring the last dose. LPN-G  t consulting with the  on duty, and after  they called the nurse  instructed to not give an  Ilin, and to check R4's  i.e.  In the RN on  itioner if there was any  In the was any  In the resident from  In the	21545				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
					02/23/2010
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - TWIN R	RIVERS	MONT STREET MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21545	Continued From page	22	21545		
	administration, provid administration, and im to ensure safe medica ongoing compliance.	e education on medication aplement an auditing system ation administration and CORRECTION: twenty one			
21665	MN Rule 4658.1400 F	Physical Environment	21665		
	•				
	by: Based on observation review, the facility failuenvironment in 8 of 14 south unit which had the residents (R69, R96, R55, R87, R44, R8, R whose rooms either lacloset doors; or whose disrepair; or who residenting area and expressions.	t is not met as evidenced  I, interview, and document ed to provide a homelike resident rooms on the the potential to affect 13 R62, R12, R71, R35, R56, R1, R50, R90, and R18) acked or had malfunctioning e rooms were in general ded between the kitchen and essed concerns related to sed concerns regarding at were too hot.			
	Findings include:				
	CLOSET DOORS/RO	OMS IN DISREPAIR			
		um Data Set (MDS) dated ne had moderately intact			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00866	B. WING		02/2	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	MONT STREET , MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21665	R69 pointed out there holes at the foot of the edge protector standing he was not aware of the and stated the disrepant bother me, it just a stated she had put not in "care tracker" [the fit tracking system] and get done, sorry to say room numbers where were either off track, replaced with a curtain During environmental a.m. with maintenance following issues were Room 21, wall go with holes, wall edge Room 22, outer of Room 24, no close Room 28, had 3 missing on inside batters and resident dreams and	en 2/22/2016, at 4:34 p.m., e were gouges, marks, and e bed, with a metal, wall ng in the corner. R69 said how the gouges got there, air in his room "Really does an old building."  ith cares in her room on etly 8:00 a.m. nursing it to close the closet door, but and non-functional. NA-D amerous requests for repair facility's maintenance stated "Evidently it doesn't //." NA-D then listed other the residents' closet doors missing, or had been in.  It our on 2/25/2016, at 10:05 the specialist (MS) the enoted:  Duges, exposed sheet rock protector removed closet door stuck on its track set doors closet door off its track " (inches) x 4" veneer hroom door ed and missing 12"x 12" floor esser set doors	21665			
	stated he was aware were, "stuck on the tra	many resident closet doors acks," and some of the ssing or removed from other				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00866		B. WING		02/25/2016		
	ROVIDER OR SUPPLIER	305 FREM	DRESS, CITY, STA	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ANOKA, IN ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
21665	and the doors were e because the closet do size doors, and there MS acknowledged the missing and broken ti sheet rock, and missi rooms. The MS state maintenance request guys," working on the completed.  During interview on 2 interim executive dire aware many of the renon-working closet do with my team" to rem stated the facility had flame-retardant mater the closet doors. ED rooms with cracked ti coming off, however,	stated he had spent, work on this [closet doors]" specially troublesome cors were custom custom, "wasn't much we could do." ee environmental concerns of alle flooring, gouges in the ng door veneer in resident and he received "80 to 100 s," and could have "2-3 erepairs to try to get them  1/25/2016, at 11:27 a.m. the actor (ED) stated she was sident rooms had cors and, "has been working ove the doors. The ED been looking at using a rial for a curtain to replace stated she was aware of the le floors, and baseboards there was no current plan in the facility would be looking,	21665			
	EXCESSIVE HALLWAY NOISE  R71's quarterly MDS, dated 12/31/2015, indicated					
	moderately impaired cognition.  R56's quarterly MDS, dated 1/7/2016, indicated intact cognition.  R50's quarterly MDS, dated 1/15/2016, indicated moderately impaired cognition.  During observation on 2/22/2016, at 7:00 p.m.					
		n 2/22/2016, at 7:00 p.m. meal, dietary staff was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1127 27.11			A. BUILDING: _				
		00866		B. WING		02	/25/2016
NAME OF P	ROVIDER OR SUPPLIER	:	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS		ONT STREET			
	I		ANOKA, M	N 55303			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21665	Continued From page	e 25		21665			
	short hall toward the recovered toward the kitchen. The toward the kitchen. The toward the kitchen warious pans used at the neared the intersection bowl and a stacked period of the fell out from the cart, resulting in crashing so and in nearby resider.  During interview on 2 stated that staff, "Coulare." R71 stated, "I haware of." R71 stated by, staff talking, and,  During interview on 2 stated staff, "talk loud the kitchen brings the "It's like a racetrack with R56 stated at least or dumped over on the first stated at the state of the state of the kitchen wards and the kitchen of the first stated of the kitchen of the first stated of the kitchen of the first stated of the kitchen of the first stated at least or dumped over on the first stated at least or dump	sounds heard in the hallw	nd bood nd ill nd vay 71 they f are g by." 856 en bm, ets				
	made.	no improvement had be	en				
	stated she heard nois pass by, and also sta	/22/2016, at 4:46 p.m. Reses as the dishes and footed it was noisy at night, leep and, "I lay there and	od and				
	dietary assistant (DA) on the main hallway a loaded with foil-cover the short hall to the di maneuvered the cart,	n 2/24/2016, at 7:31 a.m.  A exited the kitchen doo and was pushing a cart ed food trays and going t ining room. While DA-A a rhythmic sound came e cart, as if they needed	or to				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
00866		B. WING		02/2	5/2016	
NAME OF PRO	VIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1	
GOLDEN LIV	VINGCENTER - TWIN R	305 FREMO ANOKA, M	ONT STREET N 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
a find control of the second o	curther, and as the can moved toward the din continued and annour continued and annour continued and annour couring interview on 2/dietary manager (DM) esidents home, and shourry and did not think she would need to, "remoise made with the dooise from the carts, to were perhaps needed would not come off the would have maintenant Maybe they need a lisubsequent interview a new cart was just or cooking to see if more the carts.  In an interview on 2/2: where the carts to can do uneven or if they stated he had many more complete. The MS is would also be working the looking at the carts with the noisy wheels.  In an interview on 2/2: where the carts with the noisy wheels.  In an interview on 2/2: wheels with the noisy wheels.  In an interview on 2/2: wheels with the noisy wheels.  In an interview on 2/2: wheels with the noisy wheels.  In an interview on 2/2: wheels with the noisy wheels.  In an interview on 2/2: wheels with the noisy wheels.  In an interview on 2/2: wheels with the noisy wheels.	orn. DA-A pushed the cart rt rounded the corner and ing area, the noise need the cart's arrival.  (25/2016, at 8:02 a.m., at a stated the facility was the sometimes staff were in a common and a stated and a stated are and a stated are and a stated are a stated and a stated are	21665			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	l \ /	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21665	Continued From page staff" about the noise mindful" when moving	level, and, "Be more	21665			
	intact cognition. In an 4:56 p.m. R62 stated too hot." R62 stated about how hot his roo	dated 12/30/2015, indicated interview on 2/22/2016, at his room was always, "way he had complained to staff m was, and he was told,				
	about how hot his room was, and he was told, "They are working on it." R62 stated he used a fan in his room because it is so hot.  R35's annual MDS, dated 1/7/2016, indicated intact cognition. During interview on 2/22/2016, at 5:43 p.m. R35 stated she felt her room was hot in the winter, and she had complained to staff so they were aware of it.  During an environmental tour on 2/25/2016, at 10:17 a.m. with MS the following building temperatures were observed:					
	Main hallway, ne deg. F (thermostat wa Resident room # Resident room # Resident room #	25 82 deg. F 28 81 deg. F				
	stated he monitored to once a week and whe monitors, "More freque did not log any of the building, and he was by going around the be memory" of what the	5/2016, at 10:29 a.m. MS the resident room temps an it is colder outside he ently." The MS stated he temperatures in the aware of the building temps building and he had, "A good temperatures were. MS roof-top units to heat the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	EMONT STREET A, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21665	Continued From page	e 28 nallway of the facility also	21665		
	had roof top units, ea thermostats, and ther units. The MS stated heated by a boiler, ar controls to set the hear room temperature was thermostats." The MS difficult to control to m temperature. MS starresidents only covere because of the excess temperatures. The MS too hot, they could op nurses to do that." The manual of the could op nurses to do that."	ch controlled by re were a total of 8 separate resident rooms were nd there were no individual at in each room; but rather, res regulated by "sectional S stated the boilers were naintain a consistent ted he was unaware some d themselves in bed sheets			
	During interview on 2/25/2016, at 11:27 a.m. the Interim Executive Director (ED) stated if she heard a complaint about room temperatures she talks with maintenance. The ED also stated this was the first full winter the facility had to heat the building since it had new windows installed, and felt that made adjusting the building temperature challenging. The ED stated her plan to monitor temperature would be to implement a temperature log, and target a different room each day. The ED stated if there were an increase in room temps, after monitoring them, they would decrease the boiler to get the temps down  A facility environmental policy regarding resident rooms, monitoring room temperature and maintaining sound levels was requested, but none was provided.				
	SUGGESTED MFTH	OD OF CORRECTION: The			

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DM could review and revise the policies, educate

STATE FORM 6899 LZZ911 If continuation sheet 29 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02	2/25/2016
	ROVIDER OR SUPPLIER Livingcenter - Twin F	305 FRE	ADDRESS, CITY, STATE MONT STREET , MN 55303	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21665	building disrepair. The Director of nursing (Director) reporting environmen	e 29 and identify trends of repeated the DM could work with the PON to ensure staff are tal issues appropriately.  CORRECTION: Twenty-one	21665			
21810	residents shall have t medical and personal needs. Appropriate of care designed to ena highest level of physic This right is limited wi		21810			
	by: Based on observation review, the facility fail options for 1 of 1 residifficulty accessing the R56's quarterly Minim 1/7/2016, indicated in diagnoses which incluosteoarthritis and obe indicated R56 require physical assistance with steady and only able for surface to surface	e facility bathing facility.  num Data Set (MDS) dated stact cognition, and had uded amputation, esity. The MDS further ad extensive, two-person with transferring, was not to stabilize with assistance transfers. R56's care plan, notified physical functioning				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	DF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING	:	COMP	LETED
		00866	B. WING		02/	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	TATE, ZIP CODE		
GOI DEN	LIVINGCENTER - TWIN F	305 I	REMONT STREET			
GOLDEN	LIVINGCENTER - TWINT	ANO	KA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21810	Continued From page	e 30	21810			
	impairments. R56's of assistance of 2 using standing lift] and "end	care plan directed "transfer Sarah lift" [a mechanical courage choices with care." ot identify any special				
	R56 said he did not g could have a shower, only give me a bed be wont let me" use the restriction, but "don't shower." R56 curren bath, but would prefe went on to say he wa special chair, and "we that," and then sudde [staff] talked to me about the shower is said to be said	n 2/22/2016 at 6:00 p.m., et to chose whether he or bath. R56 stated "They ath." R56 also said "they whirlpool because of some know why I can't use the tly receives a weekly bed r to have a shower. R56 s getting showers, using a e never had an issue with only "around Thanksgiving bout getting just bed baths," showers even though he had eviously.				
	nursing assistant (NA whirlpool" bath, but the of some restrictions withen "was getting a state shower was difficult.	A/2016 at 11:26 a.m., a)-D said R56 "used to get a ley had to change because with the tub. NA-D said R56 hower" but positioning him in lult. NA-D then stated "I le nurse" and since then leg a bed bath."				
	on 11/23/2015, execu assessed R56 during mechanical standing safely transfer with th The note indicated th- various concerns, wit (ADLs). However the	a transfer using a lift, and was assessed to e lift and assist of 2 staff. e ED-A and R56 discussed h activities of daily living note did not identify why a bed bath, and was no				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE SU COMPLET	
		00866	B. WING		02/25	/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREM	ONT STREET N 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
21810	ED-A acknowledged I "bed baths" because August. The ED-A state determined there was chair into the shower could not accommodated and needed to be into the shower becauspace. The ED stated with R56 and was act another facility but the leave the facility.  During a tour of the neroom with ED-A on 2/demonstrated the use the shower room. ED-moving the chair arou seated, and expresse was bathed there. At R56's shower chair in room, where the whird left side of the room he faucet. There was a difloor sloped towards the was a curtain attaches the "had not consider bathing room as an a shower.  Although the facility a to be unsafe for R56, explore all bathing op	4/2016 at 11:30 a.m., the R56 was currently receiving of tube restrictions in last ated she had assessed and a safety issue placing the and felt their physical plant ate that. The ED said she ents legs to scrape on the e pushed backwards to get use of the limited shower dishe discussed concerns ively seeking placement at e resident did not want to both unit resident shower 24/2016 at 1:40 p.m., ED-A, of R56's shower chair in A explained the difficulties and in the shower with R56 did her safety concerns if R56 1:59 p.m., ED-A used to the south unit bathing pool tub was located. The add a toilet, and a sink with a train in the tile floor with the he drain. Above the drain did to the ceiling. ED-A stated red" use of the south unit alternative location for R56's sesses the facility shower the facility did not fully tions, including a possible cation for R56 within the	21810			
	A facility policy regard	ling resident				

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AND DI AN OF CORRECTION INDENTIFICATION NUMBERS		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		00866	B. WING		02/25/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	MONT STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21810	Continued From page	e 32	21810		
	accommodation of ne none provided.	eds was requested, but			
	The facility could assure updated, implement and that based on indepersonal care based oprovided to enable results.	•			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One			
21830	MN St. Statute 144.69 Residents of HC Fac.	51 Subd. 10 Patients & Bill of Rights	21830		
	Subd. 10. Participat notification of family n	tion in planning treatment; nembers.			
	(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.  (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00866	B. WING		02/25/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	305 FREM	ONT STREET			
GOLDEN LIVINGCENTER - TW	IN RIVERS ANOKA, N	IN 55303			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
21830 Continued From p	age 33	21830			
an emergency that admitted to the far family member to planning, unless to believe the residerective to the compectified in writing member included notifying a family family member to planning, the facil efforts, consistent practice, to determ executed an advace sident's health continued this paragraph, "nor (1) examining the resident; (2) examining the resident in the position of family member continued whether the resident directive and when physician to whome care; and (4) inquiring of resident normally whether the resident directive. If a facil designated emergement is particular to resident for the notification of emergency contar family member was patient's privacy in the planning that is a support to the particular to resident for the notification of emergency contar family member was patient's privacy in the planning that is a support to the privacy in the planning that is a support to the planning that is a suppor	It the resident has been collity. The facility shall allow the participate in treatment the facility knows or has reason dent has an effective advance of the facility knows the resident has at that they do not want a family in treatment planning. After the facility in treatment planning. After the facility must make reasonable with reasonable medical facility in the resident has the decisions. For purposes of the facility; any emergency contact or facted under this section and the resident has a factor of the facility; any emergency contact or facted under this section and thas executed an advance there is a family member or ency contact or allows a family that in treatment planning in this paragraph, the facility is not or damages on the grounds that the family member or enter or the participation of the simproper or violated the simproper or violated the	21830			

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STATE FORM 6899 LZZ911 If continuation sheet 34 of 47

Minnesot	<u>a Department of Health</u>	<u> </u>					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUM	BER:	A. BUILDING: _		COMPL	LIED
		00866		B. WING		02/2	25/2016
		1 00000		1		1 02/2	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	305 FREMO	ONT STREET			
COLDEN	ENTITO CENTER - TWINT	WEITO	ANOKA, M	N 55303			
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	•	Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGOLATORT ORT	EGO IDENTII TING INI GINIMA	11014)	TAG	DEFICIENCY)	INIAIL	
21830	Continued From page	e 34		21830			
	family member or des	signated emergency co	ontact.				
	the facility shall attem		,				
	_	ated emergency conta	act by				
		nal effects of the reside					
		rds of the resident in the					
		ility. If the facility is ur					
	to notify a family men						
		rithin 24 hours after the	Э				
	admission, the facility	shall notify the county	y				
	social service agency	or local law enforcem	ent				
	agency that the reside	ent has been admitted	l and				
	the facility has been u	unable to notify a famil	У				
	member or designate	ed emergency contact.	The				
		agency and local law					
		shall assist the facility					
	, ,	ng a family member o					
		cy contact. A county s					
	0 ,	al law enforcement ag	jency				
	that assists a facility						
	subdivision is not liab						
		inds that the notification					
		emergency contact of					
		mily member was imp	roper				
	or violated the patient	t's privacy rights.					
	This MNI Poquiromon	it is not met as eviden	nced				
	by:	וניוס ווטניוופנימס פעוטפוו	iocu				
	•	n, interview and docun	nent				
	review the facility fails		ion.				
		nored for getting up in	the				
		sidents (R50) reviewed					
	choices and preferen						
	Findings include:						
	DEOle aventanti M	Deta C-1 (MDC)	ما ما د ما				
		num Data Set (MDS), e e was moderately imp					

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and required extensive assistance with activities

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016
NAME OF D					1 02/23/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA MONT STREET	TE, ZIP CODE	
GOLDEN LIVINGCENTER - TWIN RIVERS			MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21830	Continued From page	e 35	21830		
	of daily living (ADL's) grooming, bathing an	d toileting.			
	· ·	/22/16, at 4:40 p.m., R50 not get to sleep in as she orning.			
	A review of R50's care plan dated 1/15/16, indicated "I may not seek assistance for my care needs. I do not like to complain." The care plan further directed staff to anticipate my care needs and offer assistance as needed with ADL's due to physical function deficit. The care plan also indicated to "Encourage choices with care." The care plan did not indicate R50 wanted to sleep in the morning.				
	During observation of the morning meal on 2/23/16, at 8:10 a.m., R50 was sitting in the dining room with her head down to her chest, sleeping with her breakfast sitting in front of her, untouched. At 8:17 a.m., R50 awakened spontaneously, and ate her breakfast. At 9:27 a.m. she was still in the dining room sitting in her wheelchair, sleeping with her chin resting on her chest. All the breakfast dishes had been removed from the dining room tables with the exception of R50's coffee cup which was sitting in front of the sleeping resident. A few minutes later staff removed the coffee cup and napkin from the resident who remained in the dining room asleep. At 9:37 a.m., R50 was assisted from the dining room by nursing assistant (NA)-A and was brought back to her room.				
	bed. At 7:05 a.m., NA and ask the resident inot. R50 stated that s	.m. R50 was asleep in her A-D, entered R50's room, if she would like to get up or the wanted to sleep in until e room. NA-D stated the			

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STATE FORM 6899 LZZ911 If continuation sheet 36 of 47

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - TWIN RIVERS  STREET ADDRESS, CITY, STATE, ZIP CODE  305 FREMONT STREET  ANOKA, MN 55303	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  305 FREMONT STREET  ANOKA, MN 55303	7.1101 27.11	A. BUILDING:		OOWII EE IEB	
GOLDEN LIVINGCENTER - TWIN RIVERS  305 FREMONT STREET ANOKA, MN 55303			00866	8. WING	02/25/2016
GOLDEN LIVINGCENTER - TWIN RIVERS  ANOKA, MN 55303	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADDR	SS, CITY, STATE, ZIP CODE	
	GOLDEN L	LIVINGCENTER - TWIN F	RIVERS		
	240.15	CHIMMADV CT		DD0//DDD0 D/ 41/ 05 005	DECTION (A.E.)
(7.1)		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A	SHOULD BE COMPLETE
resident likes to sleep in until second seating and usually gets up about 8:10-8:15 a.m. and is aware of RS0's preference to sleep in At this time, licensed practical nurse (LPN)-B joined in the conversation and stated that RS0 is a "night owl".  LPN-B stated that RS0 prefers to stay up late at night and sleep in late in the morning. Both LPN-B and NA-D stated they have worked with RS0 for a length of time and are aware of her preference of wanting to sleep in.  During observation 2/24/16, at 8:33 a.m. R50 was sleeping in bed, when approached by NA-D to awaken up for breakfast. Resident stated that she didn't wish to get up now, and wanted to wait for all little while and NA-D left the room. At 9:37 a.m. R50 was up sitting in her wheelchair, in her room, dressed, and eating breakfast of toast, coffee, and orange juice. R50 was fully awake, smilling, eating breakfast, and watching television in her room.  During interview on 2/25/16 at 8:19 a.m. registered nurse (RN)-A stated resident preference information is obtained by completing a questionnaire filled out on the day after admission. The information regarding bathing preference is utilized when coordinating bath schedules, however the information regarding wake up and bedtime preferences are not outlined on the care sheets. This information is bytically passed on with word of mouth. We don't have a really high turnover of nursing assistants, so they get to know their residents and we encourage them to pass this information no to their coworkers. RN-A stated staff should be honoring the resident choice/preference to sleep in in the morning, and it should be identified in the care plan.		resident likes to sleep usually gets up about of R50's preference to licensed practical nurconversation and stat LPN-B stated that R5 night and sleep in late LPN-B and NA-D stat R50 for a length of tin preference of wanting.  During observation 2/ sleeping in bed, wher awaken up for breakf, she didn't wish to get for a little while and Na.m. R50 was up sittli room, dressed, and e coffee, and orange jusmiling, eating breakf in her room.  During interview on 2/ registered nurse (RN) preference information a questionnaire filled admission. The inform preference is utilized schedules, however to wake up and bedtime outlined on the care stypically passed on whave a really high turn so they get to know the encourage them to patheir coworkers. RN-A honoring the resident in in the morning, and	o in until second seating and is 8:10-8:15 a.m. and is aware to sleep in. At this time, see (LPN)-B joined in the sted that R50 is a "night owl". To prefers to stay up late at the in the morning. Both sted they have worked with the and are aware of her to to sleep in.  The sl	21830	

Minnesota Department of Health STATE FORM

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	,
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	EMONT STREET A, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21830	Continued From page	e 37 d Preservation of Resident	21830		
	Rights, dated 2/26/15 identifies that "staff w preferences, needs, a	, under Resident Choice vill communicate residents			
	The administrator or or staff on soliciting and preferences, and con-	OD OF CORRECTION: designee could re-educate assessment of resident duct audits to ensure obtained, care planned, and			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one			
21855	MN St. Statute 144.69 Residents of HC Fac.	51 Subd. 15 Patients & Bill of Rights	21855		
	residents shall have to and privacy as it relat personal care program consultation, examina confidential and shall Privacy shall be respond bathing, and other according	ation, and treatment are be conducted discreetly.			
	by: Based on observation review, the facility fail to ensure personal vis	t is not met as evidenced  n, interview and document ed to implement measures sual privacy for 1 of 1 random observations.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED
			74. BOILBING.		
		00866	B. WING		02/25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	IONT STREET		
		ANOKA, I	MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	ILD BE COMPLETE
21855	Continued From page	e 38	21855		
	Findings include:				
	cognitively intact and	/27/16, identified R8 was			
	During interview on 2/22/16, at 3:05 p.m., R8 was lying in bed with the room door fully open, with a white sheet draped from his waist down, exposing his unclothed upper body. R8 stated he preferred not to wear clothing because he was too warm, and clothing was uncomfortable. R8 stated he had a fan, but needed to have his room door open because his room was too warm if the door was closed. Several unidentified facility staff passed by R8's door during this time, and made no attempts to pull R8's privacy curtain to ensure visual privacy for R8.				
	in his bed with just a s body, with his bare ch room door was open,	n 2/23/16 at 2:00 p.m. lying sheet covering his lower nest exposed. The residents and could be seen by other d staff who were walking by allway.			
	p.m., R8 was lying in exposing his unclother Residents, staff and vroom with the door op the hallway. R8 states	erview on 2/23/26, at 3:58 bed with the door fully open, ed chest and abdomen. visitor were walking by R8 ben and could be seem from d he had not been offered a n or bed that would provide			
	family member (FM)-	n 2/24/16, at 2:20 p.m., A stated she was ee R8 partially unclothed			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED
		00866 B. WING 02/25/2		02/25/2016	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	02/20/2010
GOLDEN LIVINGCENTER - TWIN RIVERS 305 FREM ANOKA, I			ONT STREET N 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21855	Continued From page	39	21855		
	and would prefer R8 to have clothing on, or something else used so she would not see R8 from the hallway.				
	During an interview on 2/24/16, at 2:10 p.m., FM-B indicated it was uncomfortable to see residents exposed skin while visiting other residents at the facility.				
	During an interview on 2/24/16, at 3:12 p.m., registered nurse (RN)-A stated, "To be honest, it's a little uncomfortable for me. I worry about his dignity and his privacy."				
	During an interview on 2/24/16, at 9:16 a.m., executive director (ED)-A indicated the facility had not assisted R8 with alternate interventions to help him to maintain his personal privacy.				
	Review of the facility's policy, Preservation of Residents' Rights, dated 2/26/15, included the facility would implement and monitor the residents' right to privacy and confidentiality.				
	The director of nursin train staff to ensure the residents, and then personal training traini	OD OF CORRECTION: g (DON) or designee could le personal privacy of erform audits to ensure o privacy is maintained.			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One			
21980	MN St. Statute 626.55 Maltreatment of Vulne	57 Subd. 3 Reporting - erable Adults	21980		
	Subd. 3. Timing of r reporter who has reas	report. (a) A mandated son to believe that a			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/25/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	305 FREM	ONT STREET			
- COLDEN		ANOKA, M	N 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21980	Continued From page	e 40	21980			
	or who has knowledg has sustained a phys reasonably explained information to the corindividual is a vulnera the individual is admit reporter is not require maltreatment of the ir to admission, unless:	ing or has been maltreated, e that a vulnerable adult ical injury which is not shall immediately report the mon entry point. If an ble adult solely because ted to a facility, a mandated d to report suspected individual that occurred prior admitted to the facility from				
	another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or  (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).  (b) A person not required to report under the provisions of this section may voluntarily report as described above.  (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.  (d) Nothing in this section shall preclude a					
	reporter from also repagency.  (e) A mandated repression to believe that 626.5572, subdivision (5), occurred must masubdivision. If the reptime believes that an agency will determine the reported error was the criteria under section, paragraph (c), classical contents.	corting to a law enforcement corter who knows or has an error under section 17, paragraph (c), clause take a report under this corter or a facility, at any investigation by a lead or should determine that is not neglect according to tion 626.5572, subdivision use (5), the reporter or to the common entry point or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_			
		00866	B. WING		02/25/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	ONT STREET			
		ANOKA, M	N 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
21980	Continued From page	e 41	21980			
	directly to the lead ag how the event meets 626.5572, subdivision (5). The lead agency	ency information explaining the criteria under section 17, paragraph (c), clause y shall consider this king an initial disposition of				
	This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to immediately report to the executive director and state agency allegations of financial exploitation for 2 of 9 residents (R97 and R12), with missing money. In addition the facility failed to thoroughly investigate 9 allegations of missing money for resident (R97, R12, R101,100,44,35,16,46 and R8).					
	Findings include:					
	R97's Minimum Data indicated she was cog	,				
	dated 7/28/15, indicate had written out a check several days prior and had 39 dollars in cash folded and tucked in a She indicated that she that check was still the gone. No noted loss key for her locked drashe had been putting under her pillow. She and check on Sunday states she feels safe	n Of Investigation form ted R97 "Reported that she ck to Destination Health d had been in wallet. She n and then had 5 -\$20 bills a different area in her wallet. e looked as wanted to see ere and her money was of credit cards, etc. Her liwer was not working and her wallet and her computer e had last seen her money y, July 26. 2015. Resident here." The Investigation rator was informed of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		LETED
		00866	B. WING		02	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, ST	ATE, ZIP CODE		
		305	FREMONT STREET			
GOLDEN	LIVINGCENTER - TWIN I	RIVERS ANG	OKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From page	e 42	21980			
		facility indicated the facility cident to the state agency				
	During interview 2/24/16, at 3:27 p.m. with the director of social services (SW) stated she does not know why the report was submitted late and it should have been reported immediately. The SW further stated the facility did a all staff meeting on 7/30/15, after the incident because of so many resident's had missing items at the facility.		<i>'</i>			
	During interview 2/25/16, at 1:00 p.m. the executive director (ED)-A stated she was the interim administrator and was unsure what happened with R97's allegation but it should have been immediately reported to the state agency.					
	R12's annual MDS di was cognitively intact	ated 10/16/15, indicated he t.				
	6/8/15, indicated "On he was missing \$20 (told the social worker back in the laundry a thought he had he missunday and noticed if He was offered a key secure the rest of his the time. He stated he with him. On 6/7/15 an additional \$9.00 fr stated he noticed it missing money and missing money and missing stated he noticed it missing stated he noticed it missing stated he noticed it missing money and missing stated he noticed it missing stated he	on of Investigation form dated (2-\$10) bills. At the time he r he thinks it might come is that happened before. He oney on Saturday and it was missing on Monday. If for his locked drawer to a money but he declined at the would keep the pouch the reported he was missing from his green pouch. He hissing on 6/5/15 and he last from was searched for money was not located.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00866		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00866	B. WING		02	2/25/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - TWIN I	305 FR	ADDRESS, CITY, STATE EMONT STREET A, MN 55303	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21980	pouch locked up. Th was not notified until incident.  A facility Verification of indicated the report of agency seven days late to ED-B and state was no longer at the should have been reported agency."  During interview 2/25 stated she does not be late to ED-B and state was no longer at the should have been reported additional review of the Investigation reports additional reports of reports additional reports of reports in the should have been reports additional reports of reports additional reports of reports additional reports of reports additional reports of reports in the should have been reports additional reports of reports additional reports of reports additional reports of reports in the should have been reports additional reports of rep	aged to keep his green e report indicated the ED 6/9/15, seven day after the of Investigation dated 6/9/15, vas submitted to the state ater.  /16, at 3:33 p.m. SW stated be if the money came back are if the previous ED-B facility at this time and it borted immediately.  Investigation indicated that old the business office missing \$20. Social worker dent and he then stated it stated he had in his green are tied to the back of his so stated the lost the key to and state agency were	21980			
	on 7/09/15, "Reported member) , nursing as	Investigation indicated that d to nurse that [sic] (staff sistant registered (NAR) had /check on her Facebook				

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STATE FORM LZZ911 If continuation sheet 44 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00866	B. WING 02/25/2		2/25/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE		
GOLDEN	LIVINGCENTER - TWIN F	RIVERS	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
21980	Resident Interview Staturther indicated: "Resident worker spoke with dashe had given the che on it for her [sic] (staff no concerns." The restate agency were im R44's Verification of I indicated R44 "had composed spouse [sic] alleges the quarters were taken for room." The report dagency were immediated R35's Verification of I indicated R16's niece with \$100.00 in her with wisiting [R35] she report had indicated were immediately information of I indicated "Resident responsible to the saw it in ago." The report didinagency were immediated R46's Verification of I indicated "Resident responsible to the saw it in ago." The report didinagency were immediated R46's Verification of I indicated "Resident responsible to the saw it in ago." The report didinagency were immediated R46's Verification of I indicated "Resident responsible to the money was missis Investigation dated 7/ niece stated R35 "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35 "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated 7/ niece stated R35" "Has with the same pouch of the money was missis Investigation dated	R101] had passed away."  Jummary on the Investigation esident had expired. Social aughter, [sic], who stated eack with sentiments written of member) to have. She had export did indicate the ED and mediately informed.  Investigation dated 7/22/15, poins in a pouch in his room, that approximately \$13 in from the pouch in residents id indicate the ED and state ately informed.  Investigation dated 7/22/15, estated R35 "Had her wallet allet and that today when orted to her it was missing."  The the ED and state agency formed.  Investigation dated 8/19/15, esported she was missing she usually wears and had did drawer in her room. She are the ED and state her the cash on 8/14/15 her pouch several days indicate the ED and state	21980			

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Minnesota Department of Health

NAME OF PROVIDER OR BUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  305 FREMONT STREET  ANDKA, IMN 53033    MAY JOD   PREDITA   GACH INFORMATION MAY SEP INFECTION SHOULD BE CRASS REFERENCED BY PAUL   PREDITA   CACHE HER CRASS REFERENCED BY PAUL   PREDIT BY PAUL   PREDITA   CACHE HER CRASS REFERENCED BY PAUL   PREDIT BY PAUL   PREDITA   CACHE HER CRASS REFERENCED BY PAUL   PREDIT BY PAUL   PREDI		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SITERET ADDRESS. CITY, STATE, ZIP CODE  305 FREMONT STREET  ANOKA, IM SSS03  (A) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IDENTIFY TAG SUMMARY STATEMENT OF DEFICIENCIES IDENTIFY TAG SUMMARY STATEMENT OF DEFICIENCIES TO THE PROPERTY TAG SUMMARY STATEMENT OF DEFICIENCIES TO THE APPROPRIATE DEFICIENCY OR SEDEMENT STREET ANOKA, IM SSS03  21980  Continued From page 45  reported to her it was missing." The report did indicate the ED and state agency were immediately informed.  R8's Verification of Investigation dated 2/12/16, indicated "Resident stated that he had \$2,00 in his wallet when he was admitted. He purchased pizza and snacks since he has been here which he thought would total \$35, With \$12 remaining he is missing approx. \$14.8." The report did indicate the ED and state agency were immediately informed.  During interview 2/25/16, at 10.47 a.m. ED-A stated these incident happened when ED-B was here, and she was unsure what happened. ED-A stated she is worined about the loss of resident money and has reimbursed each of these resident for their loss and has called the local police department. ED-A stated she had trained staff on 7/30/15 and 12/14/15 about reporting missing money/items. She suspected a former resident R68 may have been the person taking the money, but was unsure. ED-A stated the former resident R68 may have been the person taking the money, but was unsure. ED-A stated the former resident R68 may have been the person taking the money, but was unsure. ED-A stated the former resident R68 has been discharged in late December early January. Although the former resident R88 has been discharged in late December early January. Although the former resident R68 has person taking in missing money in February 8, and 12, 2016.  Although the facility had nine incidents of missappropriation of resident property from June 2015 through February 2016, there was no indication the facility completed a thorough investigation of the missing resident money.			00966	B. WING		02/25/2046	
CALL   DEFINITION   CONTROL   CONT	NAME OF P	ROVIDER OR SUPPLIER			TE. ZIP CODE	02/25/2016	
CALID   PRIEFTX   (RADI FOR PRIEF			305 FREMO	ONT STREET			
reported to her it was missing." The report did indicate the ED and state agency were immediately informed.  R8's Verification of Investigation dated 2/12/16, indicated "Resident stated that he had \$200 in his wallet when he was admitted. He purchased pizza and snacks since he has been here which he thought would total \$35, With \$12 remaining he is missing approx. \$148." The report did indicate the ED and state agency were immediately informed.  During interview 2/25/16, at 10:47 a.m. ED-A stated these incident happened when ED-B was here, and she was unsure what happened. ED-A stated she is worried about the loss of resident money and has reimbursed each of these resident for their loss and has called the local police department. ED-A stated she had trained staff on 7/30/15 and 12/14/15 about reporting missing moneyitems. She suspected a former resident R68 may have been the person taking the money, but was unsure. ED-A stated the former resident R68 discharged in late December early January. Although the former resident R68 had been discharged the facility had two additional allegations of missing money on February 8, and 12, 2016.  Although the facility had nine incidents of misappropriation of resident money.  SUGGESTED METHOD OF CORRECTION:	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
The administrator or designee could in-service all staff on the need to follow the facility abuse policy	21980	reported to her it was indicate the ED and s immediately informed.  R8's Verification of Invindicated "Resident st wallet when he was a pizza and snacks sinch he thought would total he is missing approx. indicate the ED and s immediately informed.  During interview 2/25 stated these incident here, and she was unstated she is worried money and has reimbresident for their loss police department. Et staff on 7/30/15 and 1 missing money/items. resident R68 may have the money, but was unformer resident R68 cearly January. Although ad been discharged additional allegations February 8, and 12, 2  Although the facility he misappropriation of reconstruction the facility of investigation of the misunges.	missing." The report did tate agency were  vestigation dated 2/12/16, tated that he had \$200 in his dmitted. He purchased to the has been here which it \$35, With \$12 remaining \$148." The report did tate agency were  vestigation dated 2/12/16, tated that he had \$200 in his dmitted. He purchased to the has been here which it \$35, With \$12 remaining \$148." The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The report did tate agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated \$200 in his dmitted. The purchased the local branch agency were  vestigation dated the local bran	21980			

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00866	B. WING		02/2	5/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GOLDEN	LIVINGCENTER - TWIN F	RIVERS 305 FREMO ANOKA, M	ONT STREET N 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
21980	Continued From page	e 46	21980				
	missappropriation of money to the designated state agency, throughly investicate and re-education of staff.						
	TIME PERIOD FOR ( (21) days	CORRECTION: Twenty one					

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